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VETERANS' TRAUMATIC BRAIN INJURY AND OTHER HEALTH PROGRAMS IMPROVEMENT ACT OF 2007

AUGUST 29, 2007.—Ordered to be printed

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Mr. AKAKA, from the Committee on Veterans' Affairs, submitted the following

R E P O R T

together with

SUPPLEMENTAL VIEWS

[To accompany S. 1233]

The Committee on Veterans' Affairs (hereinafter, "the Committee"), to which was referred the bill (S. 1233), to provide and enhance intervention, rehabilitative treatment, and services to veterans with traumatic brain injury, and for other purposes, having considered the same, reports favorably thereon with amendments, and recommends that the bill, as amended, do pass.

INTRODUCTION

On April 26, 2007, Chairman Akaka introduced S. 1233, the proposed "Veterans Traumatic Brain Injury Rehabilitation Act of 2007." S. 1233 would provide and enhance intervention, rehabilitative treatment, and services to veterans with traumatic brain injury. S. 1233 is cosponsored by Senators Craig, Harkin, Specter, Stevens, and Sununu.

Earlier, on January 4, 2007, Senator Obama introduced S. 117, the proposed "Lane Evans Health and Benefits Improvement Act of 2007." S. 117 would make changes in the delivery of mental health care, require the creation of an information system on veterans, and require quarterly reports on Department of Veterans Affairs

(hereinafter "VA") Medical Center performance. S. 117 is cosponsored by Senators Biden, Brown, Cantwell, Durbin, Kerry, Lincoln, McCaskill, Mikulski, Murray, Rockefeller, Salazar, Schumer, Snowe, Tester, and Wyden.

On January 24, 2007, Chairman Akaka introduced S. 383. S. 383 would extend the period of eligibility for health care for combat service in the Persian Gulf War or future hostilities from two years to five years after discharge or release. S. 383 is cosponsored by Senators Brown, Durbin, Murray, and Rockefeller.

On February 1, 2007, Senator Allard introduced S. 472. S. 472 would authorize construction of a new major medical facility in Denver, Colorado, in an amount not to exceed $523,000,000. S. 472 is cosponsored by Senator Salazar.

On February 2, 2007, Senator Obama introduced S. 692, the proposed "VA Hospital Quality Report Card Act of 2007." S. 692 would require public reports on the quality of care in VA hospitals. S. 692 is cosponsored by Senator Wyden.

On March 14, 2007, Senator Burr introduced S. 874, the proposed "Services to Prevent Veterans Homelessness Act of 2007." S. 874 would require the Secretary of Veterans Affairs to provide financial assistance to eligible entities to provide and coordinate a comprehensive range of supportive services for very low-income veteran families occupying permanent housing.

On March 27, 2007, Senator Tester introduced S. 994, the proposed "Disabled Veterans Fairness Act." S. 994 would increase the rate of reimbursement for travel to health care appointments for disabled veterans and eliminate the deductible for such reimbursement. S. 994 is cosponsored by Senators Boxer, Brown, McCaskill, Mikulski, Salazar, Sanders, Snowe, and Webb.

On March 29, 2007, Senator Chambliss introduced S. 1026, which would designate the Department of Veterans Affairs Medical Center in Augusta, Georgia, as the "Charlie Norwood Department of Veterans Affairs Medical Center." S. 1026 is cosponsored by Senators Brown, Burr, Coburn, Coleman, Graham, Hagel, Isakson, Kennedy, and Stevens.

On May 18, 2007, Senator Salazar introduced S. 1146, the proposed "Rural Veterans Health Care Improvement Act of 2007." S. 1146 would require demonstration projects on alternatives for expanding care for veterans in rural areas. S. 1146 is cosponsored by Senators Baucus, Bingaman, Burr, Byrd, Cantwell, Collins, Dorgan, Enzi, Grassley, Hagel, Johnson, Kerry, Lincoln, Murkowski, Murray, Pryor, Smith, Snowe, Stevens, Tester, Thune, and Wyden.

On April 18, 2007, Senator Murray introduced S. 1147, the proposed "Honor Our Commitment to Veterans Act." S. 1147 would allow for enrollment of Priority 8 veterans in the VA health care system. S. 1147 is cosponsored by Senators Brown, Mikulski, and Sanders.

On May 8, 2007, Senator Sanders introduced S. 1326, the proposed "Comprehensive Veterans Benefits Improvements Act of 2007." S. 1326 is an omnibus measure which proposes changes in VA health care, housing, burial, and other benefits.

On May 14, 2007, Chairman Akaka introduced S. 1384. S. 1384 would eliminate the offset of per diem payments to service centers for homeless veterans by other sources of federal funding and allow these centers to use such funds for personnel expenses; expand pro-

grams to assist individuals transitioning to civilian life from active military service and penal institutions, and require the Secretary to take appropriate actions to ensure that domiciliary care programs meet the capacity and safety needs of veterans who are women.

On May 15, 2007, Senator Specter introduced S. 1392. S. 1392 would increase the authorization for the previously authorized major medical facility project to consolidate the medical centers of the Department of Veterans Affairs at the University Drive and H. John Heinz III divisions in Pittsburgh, Pennsylvania, from $189,200,000 to $248,000,000.

On May 15, 2007, Senator Isakson introduced S. 1396. S. 1396 would authorize a major medical facility project to modernize patient wards at the Department of Veterans Affairs Medical Center in Atlanta, Georgia, in the amount of $20,500,000.

On March 27, 2007, the Committee held a hearing on Department of Veterans Affairs and Department of Defense collaboration and cooperation to meet the health care needs of returning servicemembers. Testimony was offered by: L. Tammy Duckworth, Director, Illinois Department of Veterans' Affairs; Jonathan D. Pruden, an Operation Iraqi Freedom veteran; Denise Mettie, mother of Evan Mettie and representing the Wounded Warrior Project; Bruce M. Gans, M.D., Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation; Michael J. Kussman, M.D., then-Acting Under Secretary for Health, Department of Veterans Affairs; and Ms. Ellen P. Embrey, Deputy Assistant Secretary of Defense for Force Health Protection and Readiness and Director, Deployment Health Support.

On May 23, 2007, the Committee held a hearing on pending veterans' health legislation at which testimony was offered by: Gerald M. Cross, M.D., FAAFP, Acting Principal Deputy Under Secretary for Health, Department of Veterans Affairs; Carl Blake, National Legislative Director, Paralyzed Veterans of America; Dennis M. Cullinan, Director, National Legislative Service, Veterans of Foreign Wars of the United States; Joy J. Ilem, Assistant National Legislative Director, Disabled American Veterans; Shannon Middleton, Deputy Director for Health, Veterans Affairs and Rehabilitation Commission, The American Legion; Bernard Edelman, Deputy Director for Policy and Government Affairs, Vietnam Veterans of America; Jerry Reed, Executive Director, Suicide Prevention Action Network USA (SPAN USA); John Booss, M.D., American Academy of Neurology; and Meredith Beck, National Policy Director, Wounded Warrior Project.

COMMITTEE MEETING

After carefully reviewing the testimony from the foregoing hearings, the Committee met in open session on June 27, 2007, to consider, among other legislation, an amended version of S. 1233, consisting of provisions from S. 1233 as introduced and from the other legislation noted above. The Committee voted unanimously to report favorably S. 1233, as amended.

SUMMARY OF S. 1233 AS REPORTED

S. 1233, as reported, (hereinafter, "the Committee bill") would amend the title of the original bill, and would make numerous enhancements and expansions to VA health care and services.

TITLE I—TRAUMATIC BRAIN INJURY

Section 101 would express the sense of Congress on VA's efforts in the rehabilitation and reintegration of veterans with traumatic brain injury (hereinafter, "TBI").

Section 102 would require VA to develop individual rehabilitation and community reintegration plans for veterans and servicemembers with TBI.

Section 103 would require the use of non-VA facilities, under certain specified conditions, for implementation of rehabilitation and community reintegration plans for TBI.

Section 104 would require VA to establish a research, education, and clinical care program on severe TBI.

Section 105 would require VA to carry out a pilot program on assisted living services for veterans with TBI.

Section 106 would require age-appropriate nursing home care for veterans, such as those who suffer with more severe forms of TBI.

Section 107 would require research on TBI.

TITLE II—LANE EVANS BENEFITS IMPROVEMENTS

Section 201 would extend, from two to five years following discharge, the period of time during which a veteran who served in a combat theater of operation (in the Persian Gulf War or in hostilities since that time) is eligible for VA health care.

Section 202 would require an annual report on veterans and the provision to veterans of benefits and services by VA.

Section 203 would establish a Hospital Quality Report Card Initiative to inform veterans and their families about the quality and performance of VA medical centers, utilizing existing data and reports concerning effectiveness, safety, timeliness, efficiency, and patient satisfaction. Such information would be available on the web site or promotional literature of VA medical centers.

Section 204 would require that a preliminary mental health evaluation be provided to recently discharged combat veterans not later than 30 days after a veteran requests such an evaluation.

TITLE III—HEALTH CARE MATTERS

Section 301 would rescind the Administration's January 2003 regulation which prohibited enrollment of new Priority 8 veterans.

Section 302 would require the Secretary to submit an annual report on decisions on enrollment for VA health care and to then wait 45 days before implementing any change to existing enrollment guidelines.

Section 303 would eliminate copayments for catastrophically disabled veterans for the receipt of hospital care or nursing home care.

Section 304 would authorize transportation grants for rural veterans service organizations.

Section 305 would require demonstration projects on alternatives for expanding care for veterans in rural areas.

Section 306 would require a report to Congress on matters related to care for veterans who live in rural areas.

Section 307 would increase the beneficiary travel mileage reimbursement rate from 11 cents per mile to 28.5 cents per mile for qualifying veterans who travel to VA medical facilities.

Section 308 would extend from 90 days to 180 days the application period for dental benefits following discharge from active duty.

Section 309 would exempt hospice care provided in any setting from the long-term care copayment requirement.

TITLE IV—HOMELESS VETERANS MATTERS

Section 401 would repeal the requirement that the Secretary adjust the per diem payments to homeless veterans' service centers to account for the receipt of other sources of income.

Section 402 would create a demonstration program to identify members of the Armed Forces on active duty who are at risk of becoming homeless upon discharge or release from active duty and to provide referral, counseling, and support services to prevent such members from becoming homeless.

Section 403 would expand and extend the authority for a program of referral and counseling services for at-risk veterans transitioning from certain institutions.

Section 404 would permit the use of VA grant funds to homeless service centers for personnel costs.

Section 405 would make the VA domiciliary care program for homeless veterans permanent, and would also require the Secretary to take appropriate actions to ensure that domiciliary care programs are adequate, with respect to capacity and safety, to meet the needs of women veterans.

Section 406 would require the Secretary to provide grants to eligible entities (private nonprofit organizations or consumer cooperatives) to provide and coordinate the provision of a comprehensive range of supportive services for very low-income veteran families occupying permanent housing, with preference for those transitioning from homelessness to permanent housing. It would require equitable geographic distribution of such assistance, and that the Secretary provide training and technical assistance to participating entities regarding the planning, development, and provision of such services. It would also require a 2-year study of the effectiveness of the program.

TITLE V—CONSTRUCTION MATTERS

Section 501 would authorize construction of a new VA major medical facility in Denver, Colorado, in an amount not to exceed $548,000,000.

Section 502 would increase the authorization for the major medical facility project to consolidate the medical centers of the VA at the University Drive and H. John Heinz III divisions in Pittsburgh, Pennsylvania, from $189,200,000 to $248,000,000.

Section 503 would authorize a major medical facility project to modernize patient wards at the VA Medical Center in Atlanta, Georgia, in the amount of $20,534,000.

Section 504 would authorize the appropriation of $627,329,000 for the projects authorized in Sections 501–503.

Section 505 would designate the VA Medical Center in Augusta, Georgia, as the "Charlie Norwood Department of Veterans Affairs Medical Center."

TITLE VI—OTHER MATTERS

Section 601 would reinstate until 2012 the health professional scholarship program provided for in subchapter II of chapter 76 of title 38, United States Code.

Section 602 would repeal requirements for reports on the following information: authorities to enhance retention of experienced nurses; survey of health care positions; pay for nurses and other health care professionals; long range health planning; and sharing of health care resources.

Section 603 would define the term "Post 9/11 Global Operations" to mean the period of the Persian Gulf War beginning on September 11, 2001, and ending on the date thereafter prescribed by Presidential proclamation or by law.

BACKGROUND AND DISCUSSION

TITLE I—TRAUMATIC BRAIN INJURY

Section 101 of the Committee bill would express the sense of Congress on VA's efforts in the rehabilitation and reintegration of veterans with TBI. There is a clear need for greater expertise within VA on the diagnosis, treatment, and management of TBI. VA and the Department of Defense have made progress in this area, but more should be done. The steps required by the provisions of this title would advance this goal.

The current conflicts in Iraq and Afghanistan have left a significant population of servicemembers with both moderate and severe TBI. On March 27, 2007, the Committee held a hearing on VA's ability to respond to the health care needs of returning servicemembers, including TBI. The provisions of this bill are a direct outgrowth of that hearing, especially the testimony given by those who suffer with TBI.

The brain can be harmed by the shock of an explosion or by impacts to the head as a consequence of the explosion. The symptoms of TBI are varied, complex, and subject to change over time, making diagnosis difficult.

Blast injuries account for over 60 percent of all combat wounds suffered by U.S. forces in Iraq. As of March 2007, there were 1,882 diagnosed cases of servicemembers who have suffered from TBI, and this number continues to grow. Given the high incidence of powerful explosions in Iraq and Afghanistan from Improvised Explosive Devices (IEDs), thousands of Operation Enduring Freedom (the name given to operations in Afghanistan) and Operation Iraqi Freedom (the name given to operations in Iraq) veterans, in addition to those that have been identified, may have incurred some form of brain damage or impairment that has gone undiagnosed.

Many servicemembers survive injuries which would have been fatal in previous conflicts, and often suffer brain damage in addition to other injuries. New approaches are required to meet the complex health care needs of these veterans.

The provisions in this title address the immediate needs of veterans with TBI and provide VA clinicians with additional resources to meet the lifelong needs of these veterans.

The American Legion, Disabled American Veterans, Paralyzed Veterans of America, Vietnam Veterans of America, Brain Injury Association of America, American Academy of Neurology, American Academy of Physical Medicine and Rehabilitation, American Congress of Rehabilitation Medicine, American Therapeutic Recreation Association, and the Commission on Accreditation of Rehabilitation Facilities have expressed strong support for the various provisions in this title.

Section 102 of the Committee bill would amend title 38 so as to add a new section 1710C entitled "Traumatic Brain Injury: plans for rehabilitation and reintegration into the community." This new section would require VA to develop individual rehabilitation and community reintegration plans for veterans and servicemembers with TBI who are being treated in the VA system. An individual plan is required for each veteran or servicemember because TBI takes many forms and requires close coordination of care.

Such a plan would be required prior to discharge from inpatient care or at the time of enrollment in outpatient care and would address physical, cognitive, vocational and psychosocial objectives, as well as specific treatments. It would also identify a case manager to oversee the long-term implementation of the plan and would specify dates for review of the plan. Family education and support would ensure that the veteran's needs are properly addressed.

A veteran or servicemember's rehabilitation plan would be based on a comprehensive evaluation to be conducted by a broad group of experts listed in the new subsection.

At the Committee hearing on May 23, 2007, John Booss, M.D., of the American Academy of Neurology, testified that the team approach to developing a rehabilitation plan is ideal. He also spoke about the value of including the veteran and the veteran's family in the process:

> We support the provision . . . which requires involving the family and veteran in the development and review of the rehabilitation plan. TBI is a devastating and life-altering event which affects the veteran and his or her family. Families of veterans with TBI need support and education, and should be part of the rehabilitative team to the greatest extent possible.

Joy Ilem, Assistant National Legislative Director of the Disabled American Veterans, testified at that hearing that by developing the plan before discharge from acute care, delays and missteps would be minimized.

The Committee believes that in order to ensure that each veteran or servicemember who is treated at VA for TBI receives appropriate and high-quality care suited specifically to the needs of the patient, these plans must be mandated, and families must be a part of the process. Some of the more severely wounded individuals will require others to monitor the implementation of the plan, get them to appointments, and otherwise assist them in various aspects of their recovery, and as such, inclusion of family caregivers is imperative.

Section 103 of the Committee bill would amend title 38 so as to add a new section 1710D, entitled "Traumatic Brain Injury: use of non-Department facilities for rehabilitation." This new section would require the use of non-VA facilities for implementation of rehabilitation and community reintegration plans for traumatic brain injury under certain specified circumstances. Non-VA facilities would be used when the Secretary cannot provide treatment or services at the frequency or for the duration required by the veteran or servicemember's individual plan, or when the Secretary determines that it is optimal for the veteran or servicemember's recovery and rehabilitation.

VA has done much to develop the capability to treat TBI. However, VA has only recently begun treating younger veterans with those debilitating injuries. As such, in some circumstances, VA may find the service of a non-VA facility to be better suited to providing the care required by some veterans with TBI.

Section 104 of the Committee bill would amend title 38 so as to add a new section 7330A, entitled "Severe traumatic brain injury research, education, and clinical care program." This new section would require VA to develop and implement a research, education, and clinical care program on severe traumatic brain injury. Given the complexity of TBI, and the wide range of symptoms, there is a clear need for additional research on all aspects of this injury. A better understanding of the nature of TBI will lead to better care and treatment.

To carry out the programs under this proposed new section, $10,000,000 would be authorized to be appropriated for each of fiscal years 2008 through 2012.

Shannon Middleton, Deputy Director for Health, Veterans Affairs and Rehabilitation Commission of The American Legion, testified before the Committee on May 23, 2007, in support of the research provisions in section 104 as well as those in section 107, described below. Carl Blake, National Legislative Director, Paralyzed Veterans of America, and Dennis M. Cullinan, Director, National Legislative Service, Veterans of Foreign Wars of the United States, expressed similar support for this research at that hearing.

Section 105 would require VA, in collaboration with the Defense and Veterans Brain Injury Center, to carry out a pilot program during a five-year period on assisted living services for veterans with traumatic brain injury. As veterans and servicemembers recovering from TBI reintegrate back into their communities and progress with rehabilitation, they will require significant support. VA has made progress in providing effective support, and this pilot program will bring greater attention to this important area of care.

The pilot program would be carried out in locations selected by the Secretary, with at least one in each health care region of the Veterans Health Administration that contains a polytrauma center. Other locations shall be in areas with high concentrations of veterans with TBI. Special consideration for veterans in rural areas would also be required to improve access to VA care in these areas. Long-term care is often sparsely available in rural locations. The Committee bill, in giving special consideration to veterans and servicemembers in rural areas, seeks to ensure that those who do not reside in areas with the highest population concentrations will still have access to assisted living services.

In carrying out this pilot program, the Secretary would be authorized to enter into agreements with providers participating under a State plan or a waiver under title XIX of the Social Security Act contained in section 1396 of title 42, United States Code.

To carry out this pilot program, $8,000,000 would be authorized to be appropriated for each of the fiscal years 2008 through 2013.

Section 106 of the Committee bill would amend section 1710A of title 38 to require VA to provide age-appropriate nursing home care to veterans, such as those who suffer with more severe forms of TBI. The deployment of over 1.5 million soldiers around the globe in the wake of September 11, 2001, has resulted in a growing number of young men and women who will require nursing home care for the foreseeable future due to catastrophic injuries, including TBI.

This population of veterans has needs and expectations very different from those of older veterans. The Committee firmly believes that VA must address the needs of this generation with new services and environments that are geared specifically towards the long-term care needs of younger veterans.

Section 107 would require that, as part of VA's overall research activities, the Department carry out research on the sequelae of TBI. Of particular importance are visually-related neurological conditions, seizure disorders, and research on means of improving diagnosis, treatment, and prevention of such sequelae.

The Committee notes that tinnitus has been demonstrated to be caused by blast injuries and frequently accompanies TBI. The genesis and nature of this condition require further study.

John Booss, M.D., testified at the Committee's May 23, 2007, hearing on the need for extensive additional research, particularly in the area of post-traumatic epilepsy, resulting from penetrating or blast TBI:

> This condition has been thoroughly documented among Vietnam veterans. For service-connected Vietnam veterans, the relative risk for developing epilepsy more than 10 to 15 years after their [TBI] injury was 25 times higher than their age related civilian cohorts . . . At one point, the VA was a national leader in care and research for patients with epilepsy . . . But starting in the 1990's these epilepsy centers have languished due to lack of funds.

Joy Ilem of the Disabled American Veterans also testified to the importance of this research, and to the need for revitalizing VA's Epilepsy Centers of Excellence.

TITLE II—LANE EVANS BENEFITS IMPROVEMENTS

This title of the Committee bill is named for Representative Lane Evans. He has devoted his adult life to serving our Nation and its veterans. Evans joined the United States Marine Corps in 1969, and served until 1971 in the U.S. and in Okinawa, Japan. In 1982, after completing law school at Georgetown University, Evans was elected by his home town district of Rock Island, Illinois, to the United States House of Representatives. For the next 24 years, Evans served on the House Veterans' Affairs Committee. In 1997, he was chosen as the Ranking Democratic Member, where he remained for 10 years. Representative Evans was a hard hitting ad-

vocate for veterans. He did not seek reelection to the House in 2006 due to the debilitating effects of Parkinson's disease, but he has remained strong in his conviction and actions in championing veterans and their rights. His voice in the House of Representatives is missed.

Section 201 of the Committee bill, which is drawn from S. 383, would amend section 17101(e)(3)(C) of title 38 United States Code so as to extend the period during which veterans of combat after the Persian Gulf War have eligibility for VA health care, without regard to other criteria, from two to five years. In 1998, Congress enacted the Veterans Programs Enhancement Act, (P.L. 105–368), section 102 of which gave two years of priority eligibility for health care to any veteran who served in a combat theater of operations following discharge or release from active duty.

The extension is necessary to ensure veterans returning from combat receive health care during their transition from military to civilian life. With this extension, physical and mental health disorders, including post-traumatic stress disorder (hereinafter, "PTSD"), which may take years to manifest and treat, will be better addressed. VA and the veterans service organizations expressed support for this provision in their testimony of May 23, 2007, and the Committee has found wide support for this provision over the course of its oversight activities.

Section 202 of the Committee bill, which is derived from S. 117, would add a new section 530A to title 38 under which VA would be required to provide specific information to the Committees on Armed Services, Appropriations and Veterans' Affairs of the Senate and House concerning the benefits and services provided to veterans who have served in the period of the Persian Gulf War since September 11, 2001.

VA is required to provide a variety of reports to Congress. Many of those reports provide information concerning veterans who served during the time period known as the "Persian Gulf War" which, for purposes of title 38, United States Code, began on August 2, 1990, and has not ended. However, those reports do not generally recognize and account separately for the benefits and services used by persons who have served since September 11, 2001, in the Post 9/11 Global Operations theater. During that time, the United States has engaged in military action in Afghanistan, Iraq and various other countries and locations. In order for Congress to provide effective oversight of the benefits and services provided to veterans of this service, the Committee finds that additional specific information is needed.

Under new section 530A, the Secretary would be required to provide an annual report containing demographic and other information on veterans who participate in a covered tour of duty during the period beginning September 11, 2001. The report would require separate information concerning veterans who served only in Afghanistan, only in Iraq, in both Afghanistan and Iraq, the Post 9/11 Global Operations theater (determined by reference to the geographic locations specified for award of the Global War on Terrorism Expeditionary Medal) and any other location.

Veterans who served in Afghanistan, but who did not serve in Iraq or any other Post 9/11 Global Operations theater, would be considered veterans who served only in Afghanistan. The Com-

mittee intends that data concerning veterans who served only in Afghanistan would be determined by award of the Afghanistan campaign medal or other evidence of military service in Afghanistan. Veterans would be considered to have served only in Iraq if they did not serve in Afghanistan or any other Post 9/11 Global Operations theater. The Committee intends that data concerning veterans who served only in Iraq would be determined by award of the Iraq campaign medal or other evidence of military service in Iraq.

The Committee intends that a veteran who served in both Afghanistan and Iraq with or without service in other locations identified in the Post 9/11 Global Operations theater would be categorized under the covered tour of duty for both Iraq and Afghanistan. The Committee intends that data concerning a veteran who served in the Post 9/11 Global Operations theater would be determined by award of the Global War on Terrorism Expeditionary Medal or other evidence of military service in the geographic locations which qualify a veteran for such an award.

In addition to demographic information such as sex, age, marital status, residence, Armed Force, Reservist and separation status, the Secretary would be required to provide other information for each covered tour of duty category, such as the number of claims for service-connected compensation, the average amount of monthly compensation paid at each rating level (the number of veterans paid at each percentage level and the average monthly amount paid to such veterans at each level), claims for Dependency and Indemnity Compensation (DIC), claims for non-service-connected pension, veterans provided services by Vet Centers including use by members of the National Guard or Reserves, the provision of health services including inpatient and outpatient services, the location where such services were provided, including separate information for veterans served by a specialized care facility such as a polytrauma center, information on the number of veterans since December 31, 2002, who have been diagnosed with or treated for PTSD, depressive disorders, neurotic disorders, substance abuse disorders, acute reaction to stress, or other mental disorders as determined by the Secretary. This additional information will facilitate effective Congressional oversight.

In addition to the annual report, the Secretary would be required to provide a quarterly report with information concerning the number of claims for service-connected compensation and non-service connected pension which have been received and processed, and the number which are pending, have been granted, or have been denied. This information is similar to that currently provided by the Veterans Benefits Administration's Gulf War Veterans Information System. However, that report provides specific data concerning veterans who served in Southwest Asia during the period ending on July 31, 1991, but does not provide such specific information for veterans who have served since September 11, 2001.

The purpose of these reports is to provide the Committees with information to enable them to conduct oversight of VA and to identify the need for changes in legislation warranted by the specific benefit and health care needs of veterans who have served since September 11, 2001. During the Committee's hearing on May 23, 2007, Shannon Middleton, Deputy Director, Veterans Affairs and Rehabilitation Commission of The American Legion, expressed sup-

port for the provisions of S. 117. Ms. Middleton noted that "differentiating veterans who served in OIF, OEF, those who served in both and those who served in neither will also be important when anticipating long-term health effects."

Section 203 of the Committee bill, derived from S. 692, would add a new section 1730A to title 38, United States Code, which would require VA to establish a Hospital Quality Report Card Initiative to inform veterans and their families of the quality and performance of VA hospitals. The initiative is intended to assist veterans and their families in making informed health care choices, and to raise public awareness and understanding of hospital quality issues.

Under this section, the Secretary would be required to incorporate current information on facility performance in the web site or promotional literature of each VA hospital. The information, which would cover performance measures in the areas of effectiveness, safety, timeliness, efficiency, and patient satisfaction, would be obtained from sources determined appropriate by the Secretary. These could include the Joint Commission on Accreditation of Healthcare Organizations, the Office of Inspector General or Office of the Medical Inspector, other offices involved in the collection of hospital performance data, media outlets, and professional journals. Additionally, the Secretary would be required to ensure that the information is posted in a manner conducive for comparisons with other local or regional hospitals.

A list of Internet links and data summaries on the web site or brochure of each VA hospital would publicize a large volume of practical information that was previously inaccessible or unknown to most VA patients and other stakeholders. It would also serve to further accountability and openness in the VA health care system. Subject to individual privacy concerns, all relevant metrics and reports would be made available to the public at large.

Section 204, which is also drawn from S. 117, would amend section 1702 of title 38, United States Code, so as to require that VA provide a preliminary mental health evaluation to a recently discharged combat veteran not later than thirty days after a request for such an evaluation.

While VA has made significant efforts to provide veterans with mental health evaluations in a timely manner, there is much room for improvement. VA has made progress in reaching out to servicemembers in need of services, and should continue to make commensurate efforts to provide those services in a timely way.

This provision has broad support from the veterans' service organizations, including Paralyzed Veterans of America, Veterans of Foreign Wars of the United States, Disabled American Veterans, The American Legion, and Vietnam Veterans of America.

TITLE III—HEALTH CARE MATTERS

Section 301 of the Committee bill, which is derived from S. 1147, would rescind section 17.36(c) of title 38, Code of Federal Regulations, the January 2003 regulation which halted the enrollment of Priority 8 veterans into VA health care. Priority 8 veterans are those whose income level exceeds the Department of Housing and Urban Development's "low-income" geographic means test, as defined in section 1437a of title 42, United States Code.

On January 17, 2003, former Secretary of Veterans Affairs Anthony J. Principi issued a regulation which precluded Priority 8 veterans from enrolling in the Veterans Health Administration. On February 26, 2003, former Secretary Principi, in testimony before the Committee, stated that the ban on Priority 8 enrollments would be temporary until VA could better meet veterans' expectations, with particular attention to timely access to care. However, the prohibition on Priority 8 veterans has continued to the present, and veterans who need and deserve care are being turned away.

In the Committee's Views and Estimates letter submitted by the Democratic Members of the Committee and Senator Sanders to the Budget Committee on March 1, 2007, the Majority members recommended including sufficient funding to allow VA, in fiscal year 2008, to accommodate Priority 8s in the total medical care funding allocation. The Budget Committee and the full Senate subsequently supported this funding authorization level in the Fiscal Year 2008 Budget Resolution, and it was included in the final Budget Resolution adopted by both the House and the Senate.

Section 302 would require that the Secretary annually, by August 1, publish notice in the Federal Register of which categories of veterans are eligible to be enrolled in VA health care in the coming fiscal year.

Also, in any year in which the Secretary proposes to restrict enrollment, the Secretary would be required to provide an estimate of the cost of enrolling all eligible veterans to the Committees on Veterans' Affairs of the House and Senate.

After proposing the August 1 notice, the Secretary would be required to wait 45 days before implementing any change in enrollment. This notice-and-wait requirement would provide Congress with an opportunity to oversee the enrollment of veterans in the Veterans Health Administration, and to respond to any proposed limitation on enrollment.

It is the view of the Committee that when resources are provided by Congress to enable the Department to keep pace with demand for services, as set forth in section 1705 of title 38, United States Code, the system should be open to all veterans who seek care.

Section 303 of the Committee bill, which is derived from S. 1326, would amend section 1710 of title 38, United States Code, so as to eliminate the requirement that "catastrophically disabled veterans" make copayments for the receipt of hospital care or nursing home care.

The veterans who would be affected by this change, such as those with spinal cord injury, require ongoing care and services. Private insurers do not cover this kind of service, and most other health programs do not offer the level of care provided by VA. These veterans should not be required to pay fees and copayments for their care, as they utilize and rely on VA health care at a much higher rate than many other veterans.

Paralyzed Veterans of America testified in support of this provision before the Committee on May 23, 2007.

Section 304 of the Committee bill, which is derived from S. 1146, would require the Secretary to establish a grant program to provide innovative transportation options to veterans in rural areas.

Over 1.5 million servicemembers have been deployed in operations OEF and OIF, of which over 686,000 have already been dis-

charged. A significant portion of these forces are members of the National Guard and Reserve. After discharge from active duty, many of those who have served will return to small towns across the country, often many miles from military bases and VA facilities.

The provisions in section 304 would authorize grants for rural veterans' service organizations and community-based organizations to provide innovative transportation options to veterans in remote rural areas. For each fiscal year 2008 through 2012, $6,000,000 would be authorized to be appropriated for this grant program. No individual grant may exceed $50,000. The grants would be awarded to State veterans' service agencies, veterans service organizations, and qualified community transportation organizations.

Community transportation organizations range from public sector entities—either at the federal (generally through the Department of Transportation or through Medicaid) or state level—to nonprofit private entities, and often employ a combined network of public and private methods of transportation (such as taxicabs) to help patients get to their health care appointments. The Committee bill would enable VA to utilize these already existing networks at the local level to provide transportation to veterans who need to get to a VA facility for care.

The Committee recognizes the need for transportation alternatives for rural veterans since these veterans do not have the same access to public transportation that urban and suburban veterans do. The program currently run by the Disabled American Veterans is another successful model, and the Committee encourages building on and expanding this program.

Section 305 of the Committee bill, derived from S. 1146, would require demonstration projects on alternatives for expanding care for veterans in rural areas. Under the provision, two demonstration projects would be required to be carried out in geographically dispersed areas. As part of these projects, VA would be required to partner with the Department of Health and Human Services, and to coordinate with the Indian Health Service to expand care for Native American veterans.

The need for innovative options for ensuring access to care for rural veterans is also an issue of concern to the Committee. While the Committee recognizes that the integrity of the VA system as a whole must be preserved, there is clearly room for increased collaboration with other federal agencies in areas where VA cannot effectively or efficiently reach veteran patients.

Section 306 of the Committee bill, also derived from S. 1146, would require VA to submit a report to Congress on matters related to care for veterans who live in rural areas. The report would be submitted with the annual budget proposal.

This report would be required to include information on the implementation of sections 304 through 306 of the Committee bill, the establishment and function of the Office of Rural Health, the establishment of a partnership between VA and the Centers for Medicare and Medicaid Services of the Department of Health and Human Services, and on plans for VA to employ the use of telemedicine to serve rural veterans.

The first such report would be required to contain information on the fee-basis health-care program required by subsection (b) of sec-

tion 212 of the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Public Law 109–461), and the outreach program required by section 213 of that public law.

Section 307 of the Committee bill, which is derived from S. 994, would amend section 111(g) of title 38, United States Code, relating to payments to qualifying veterans for travel to VA medical facilities. At present, veterans are compensated at the rate of 11 cents per mile for routine visits and 17 cents per mile for Compensation and Pension examinations, subject to, under most circumstances, a deductible of $3 per one-way trip. These mileage rates are not set in statute, but rather are left to the discretion of the Secretary. However, the rates have not changed since 1978.

This section is designed to modernize VA's beneficiary travel program and bring payments under the program closer in line with today's cost of travel, taking into account the cost of fuel and vehicle maintenance. It would direct the Secretary to reimburse qualifying veterans at the particular rate authorized for Government employees under section 5707(b) of title 5, United States Code, which presently stands at $.28 per mile. By linking VA mileage reimbursement to a Government rate, periodic increases in the rate would be guaranteed. The Administrator of General Services, who prescribes Government mileage rates under title 5, generally raises them no less often than once every two years. Thus, a situation whereby reimbursements stagnate for 30 years would not be repeated.

Additionally, this section would strike a provision that allows the Secretary to raise or lower the deductible for reimbursements in proportion to a change in the mileage rate. This would have the effect of holding the deductible at $3 per one-way trip until such rate is changed by law, irrespective of future increases to the Government rate. Under this approach, the deductible will likely eventually become inconsequential relative to the average reimbursement payout.

The Committee expects that this section will provide the most benefit to veterans living in remote rural areas, some of whom must drive hundreds of miles each month to receive essential VA health care, by ensuring reimbursement at a fair rate that defrays the cost of travel expenses.

Section 308 of the Committee bill would amend section 1712(a)(1)(B)(iv) of title 38, United States Code, so as to extend from 90 days to 180 days the period during which recently discharged servicemembers can apply for VA dental benefits.

Under current law, returning servicemembers must apply for dental benefits within 90 days from the date of discharge. Recently returned servicemembers often face significant challenges readjusting, and dental concerns may not be a top priority. In addition, members of the National Guard and Reserve are often given 90 days of leave following discharge from active duty, and upon return to their units the opportunity to apply for dental benefits has passed.

The Committee believes that the extension to 180 days would improve access to care and facilitate a smoother transition from military to civilian life.

Section 309 of the Committee bill would amend section 1710 of title 38, United States Code, so as to exempt hospice care provided

in all settings from the copayment requirement for VA long-term care. Under current law, only hospice care provided in a VA nursing home is exempted from copayment. The Committee believes that this system is inequitable and creates institutional bias, as many veterans choose to receive hospice care in nursing homes rather than in other settings to avoid daily copayments.

TITLE IV—HOMELESS VETERANS MATTERS

Section 401 of the Committee bill, which is drawn from S. 1384, would amend section 2012(a)(2) of title 38, United States Code, so as to eliminate the authority of the Secretary to offset per diem payments to homeless service providers by the amount of non-VA funding they receive. Per diem payments from VA compensate service centers for homeless veterans for the services they provide to veterans. The current rate of $27 per day for each veteran served is not sufficient to cover existing costs, and rising energy prices and other external factors have placed increasing strain on current resources.

To meet the needs of their clients, many shelters must seek additional sources of funding. Under current law, VA per diem payments are reduced in proportion to non-VA funding. The amendment proposed by section 401 of the Committee bill would eliminate this offset. This will enable service centers to expand their services with these additional resources and incentivize new programs to get off the ground.

Section 402 of the Committee bill, which is also derived from S. 1384, would require VA to carry out a demonstration program to identify members of the Armed Forces on active duty who are at risk of becoming homeless upon discharge or release from active duty and to provide referral, counseling, and support services to prevent such members from becoming homeless. The Committee does not believe that a significant portion of separating servicemembers are at risk of immediate homelessness, but certain indicators can help identify those individuals who may in the future be at risk of homelessness. This program will allow and encourage preventive action before a veteran becomes homeless. It is imperative for those who are at-risk of homelessness to be identified as early as possible following their discharge to prevent them from becoming homeless.

A similar program, discussed below under section 403 of the Committee bill, to aid incarcerated veterans who may be at risk of becoming homeless in their transition back to civilian life, has been largely successful and warrants replication. VA, in testimony addressing a similar proposal to that of the Committee bill, H.R. 5960, introduced in the 109th Congress by Representative Michaud, expressed support for a program like this.

This program would be required to be carried out in at least three locations, and $2,000,000 would be authorized to be appropriated. The authorization for this program would expire in 2011. The Secretary would be authorized to enter into contracts for services with such entities or organizations as the Secretary deems appropriate.

Section 403 of the Committee bill, which is also derived from S. 1384, would amend section 2023 of title 38, United States Code, so as to extend and expand the authority for a program to aid in-

carcerated veterans in their transition back to civilian life. The program would be extended until September 30, 2011, and would be expanded to twelve locations. The program identifies at risk individuals prior to their discharge and refers them to counseling and services, including health care, job training and placement, and housing.

The demonstration program that section 403 would extend has proven to be widely successful. Seven sites were chosen nationwide as pilot sites, and the program is funded and administered primarily through the Department of Labor's Homeless Veterans Reintegration Program (hereinafter, "HVRP"), another successful program. HVRP employs a collaboration of nonprofit, state and federal entities, including VA, to carry out the programs.

Subsection 404 of the Committee bill, which is also drawn from S. 1384, would amend section 2011 of title 38, United States Code, so as to permit the use of VA grant funds for homeless service centers for personnel costs. Under current law, grants made to homeless service centers may not be used for personnel costs which are essential to the daily operations of such centers. Yet, these daily operational costs are burdensome to homeless service providers. The Committee bill would give providers more flexibility in spending VA grant funds for the purpose of serving homeless veterans.

Subsection 405 of the Committee bill, which is also drawn from S. 1384, would amend section 2043 of title 38, United States Code, to make permanent an existing authority to expand domiciliary care for homeless women veterans.

Women veterans are a growing proportion of the military and veteran population, and homelessness affects a significant proportion of the veteran population as a whole. Many VA facilities do not yet have adequate capacity to meet the needs of these veterans. Domiciliary care is an essential component of the services for homeless veterans, especially for mental health and substance abuse treatment programs.

This provision would require VA to ensure that domiciliary programs have the capacity to accommodate the specific needs of women veterans. While VA is already undertaking many efforts to improve capacity and services for women veterans and specifically direct programs and sections of medical care facilities to meet the needs of these patients, the Committee believes it is necessary to codify the need for maintaining capacity and specialized services in the domiciliary care program for women veterans.

Section 406 of the Committee bill, which is derived from S. 874, would amend title 38 so as to add a new section 2044, relating to supportive services for very low-income veterans and their families occupying permanent housing. The Committee is concerned that some of the servicemembers deployed to Iraq and Afghanistan will be at risk for homelessness upon separation from active duty, in addition to older veterans who are struggling to maintain employment or are faced with other financial issues. Preventive efforts by VA to support transitioning servicemembers and veterans can reduce this number, and reduce the demand for VA services in the future.

The provisions in the new section 2044 would direct VA to provide grants to eligible entities to provide and coordinate the provision of a comprehensive range of supportive services for very low-

income veteran families occupying permanent housing, including those transitioning from homelessness to such housing. Those families may be occupying permanent housing, moving into permanent housing within 90 days, or moving from one permanent residence to another to better suit their needs.

Entities eligible to receive grants under this provision are public or private nonprofit organizations which have demonstrated the capacity and experience necessary to deliver the services outlined in the proposed new section, described below.

Under the provisions of the new section 2044, grants would be provided for a wide range of services, so as to give families a broad set of tools to maintain a permanent residence. To this end, providers could receive grants to furnish outreach, case management, assistance in obtaining and coordinating VA benefits, and assistance in obtaining and coordinating other public benefits provided by federal, state, or local agencies or organizations.

The Committee believes that the following services, in addition to others, help families maintain permanent housing: health care and health insurance, daily living services, personal finance planning, transportation, income support, fiduciary and representative payee services, legal services, child care, and housing counseling.

VA would be required to ensure equitable geographic distribution of assistance under the new authority, including in rural and on tribal lands.

Under subsection (c) of section 406 of the Committee bill, VA would be required to study the effectiveness of this permanent housing program compared to other programs delivering housing and services to veterans, and submit a report on that study to the Committees on Veterans' Affairs of the House and Senate by March 31, 2010.

Subsection (d) of the new section 2044 would require VA, through the authority in section 2064 of title 38, to provide training and technical assistance to participating entities regarding the planning, development, and provision of services.

For the programs that would be authorized by new section 2044 of title 38, the following funds would be authorized to be available from amounts appropriated to VA for Medical Services: $15,000,000 in Fiscal Year 2008, $20,000,000 in Fiscal Year 2009, and $25,000,000 in Fiscal Year 2010. Of these funds, not more that $750,000 would be available in any fiscal year for technical assistance; however, there is specific authorization for $1,000,000 to be appropriated to carry out the technical assistance in each of the fiscal years 2008 through 2010.

Veterans of Foreign Wars of the United States, Paralyzed Veterans of America, and Vietnam Veterans of America expressed their support for the provisions under section 406 in testimony before the Committee on May 23, 2007.

In testimony before the Committee at the May 23, 2007, hearing, VA presented views opposing an earlier version of the provisions under section 406. The Committee bill's provision contains many of the changes suggested by VA.

TITLE V—CONSTRUCTION MATTERS

Section 501 of the Committee bill, which is derived from S. 472, would authorize construction of a new major medical facility in

Denver, Colorado, in an amount not to exceed $548,000,000. Last year, in S. 3421 as reported in the Senate, the Committee authorized $52,000,000 in land acquisition funds for the commencement of this project, to be carried out in collaboration with the University of Colorado. This amount was increased to $98,000,000 in the final bill as signed into law.

However, due to potential increases in the total cost of the project due the incremental authorization process that VA has undertaken as part of their capital plan, the Committee believes the total amount of the project needs to be authorized in order to attempt to keep construction costs contained.

Section 502 of the Committee bill, which is derived from S. 1392, would increase the authorization for the major medical facility project to consolidate the medical centers of the VA at the University Drive and H. John Heinz III divisions in Pittsburgh, Pennsylvania, from $189,200,000 to $248,000,000. Due to VA's plan to request appropriations for this project on an incremental basis, the total cost of the project has increased from previous authorizations and a new authorization for the total cost of the project is necessary.

Section 503 of the Committee bill, which is derived from S. 1396, would authorize a major medical facility project to modernize patient wards at the VA Medical Center in Atlanta, Georgia, in the amount of $20,500,000. The Department of Veterans Affairs expected to complete this construction prior to the end of the previous authorization, but additional time is required. As the project is already fully funded, no new appropriation is required.

Section 504 of the Committee bill would authorize the appropriation of $627,329,000 for the major medical facility projects authorized in sections 501 through 503.

Section 505 of the Committee bill, which is derived from S. 1026, would designate the VA Medical Center in Augusta, Georgia, as the "Charlie Norwood Department of Veterans Affairs Medical Center".

Charlie Norwood served as a Member of the United States House of Representatives from 1995 until his death on February 13, 2007. At the time of his death, Norwood was the Representative of the 10th District of Georgia. He served as a Captain in the United States Army from 1967 to 1969, beginning with an assignment to the U.S. Army Dental Corps. He served on forward bases in Vietnam, and in the United States. Representative Norwood meets Committee requirements for naming of VA facilities.

TITLE VI—OTHER MATTERS

Section 601 of the Committee bill would amend section 7618 of title 38 United States Code to reinstate the authority for the Health Professional Scholarship Program until 2012. This program, which expired in 1998, is an essential element of the VA's Nursing Academy, a collaborative program established between the Office of Academic Affiliations and the Office of Nursing Services. The financial assistance awarded to competitive candidates is intended to improve recruitment and retention and, broadly, help reduce the national nursing shortage.

This program was originally established by P.L. 96–330 and awarded scholarships from 1982 until 1995 to 3,300 students. Authority for the program was extended through 1998, but was dis-

continued in 1998 in favor of other recruitment options. Two similar programs, the Employee Incentive Scholarship Program and the Education Debt Reduction Program, were implemented in March 2000 and awarded 4,905 scholarships by March 2003. In the face of ongoing nursing shortages, the Committee finds that the Health Professional Scholarship Program should be reauthorized.

Section 602 of the Committee bill would eliminate a number of reports required by current law.

The report on "Use of Authorities to Enhance Retention of Experienced Nurses" was implemented by VA to improve retention of experienced nurses. It has been in place for some time and has fulfilled its purpose.

The report on "Survey of Health-Care Positions" was implemented in 2000 to ensure that the locality pay system was adequately addressing VA nursing staff needs. This report has demonstrated the effectiveness of the salary surveys and has fulfilled its purpose.

The report on "Pay for Nurses and Other Health Care Personnel" is of minimal value because nurses are now guaranteed at least the annual general pay increase.

The information contained in the report on "Long Range Health Planning" is already contained in VA's budget proposals and in the five-year strategic plans. As such, this report is redundant.

The Committee believes that the information contained in the report on "Sharing of Health-Care Resources" would be more efficiently presented in the annual budget submission.

Section 603 of the Committee bill would clarify that the term "Post 9/11 Global Operations" means the period of the Persian Gulf War beginning on September 11, 2001, and ending on the date thereafter prescribed by Presidential proclamation or by law.

This term differentiates periods of time, and its use will be helpful in identifying periods of service. Use of this term will also allow for greater precision in statistical analysis of military operations and service. Currently, the "Persian Gulf War" period that began back in 1991 is ongoing.

COMMITTEE BILL COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the CBO, estimates that enactment of the Committee bill would, relative to current law, increase discretionary spending by $1.4 billion in 2008 and by $10.6 billion over the 2008–2012 period, assuming appropriation of the necessary amounts. The Committee bill would increase direct spending by less than $500,000 in 2008, and by $3 million over the 2008–2012 period. Enactment of the Committee bill would not affect receipts, and would not affect the budget of state, local or tribal governments.

The cost estimate provided by CBO, setting forth a detailed breakdown of costs, follows:

CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 23, 2007.

Hon. DANIEL K. AKAKA,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 1233, the Veterans Traumatic Brain Injury and Health Programs Improvement Act of 2007.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Michelle S. Patterson, who can be reached at 226–2840.

Sincerely,

PETER R. ORSZAG,
Director.

Enclosure
cc: Honorable Larry E. Craig, Ranking Member.

S. 1233—Veterans Traumatic Brain Injury and Health Programs Improvement Act of 2007

Summary: S. 1233 would create new programs to treat combat veterans with traumatic brain injuries, authorize the construction of hospitals for the Department of Veterans Affairs (VA), and expand health care benefits for veterans. In particular, S. 1233 would allow veterans without disabilities related to military service to enroll in the VA health care system regardless of their income level.

The bill also has two provisions that would modify a VA program that funds hundreds of community agencies that provide services to homeless veterans, potentially allowing those service providers to receive significantly increased funding. CBO cannot determine the costs of those provisions at this time because neither VA nor CBO can predict how the service agencies would alter their requests for VA funding under S. 1233; however, CBO expects the annual cost of those two provisions would probably be in the tens of millions of dollars. CBO estimates that implementing the remainder of S. 1233 would increase discretionary costs for veterans' health care by about $1.4 billion in 2008 and $10.6 billion over the 2008–2012 period, assuming the appropriations of the necessary amounts. In addition, CBO estimates that enacting the bill would increase direct spending by less than $500,000 in 2008 and $3 million over the 2008–2012 period. Enacting the bill would have no effect on federal revenues.

S. 1233 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act; any costs to state, local, or tribal governments would result from complying with conditions of federal assistance.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 1233 is summarized in Table 1. The costs of this legislation fall within budget function 700 (veterans benefits and services).

Table 1. Estimated Budgetary Impact of S. 1233

	By fiscal year, in millions of dollars—				
	2008	2009	2010	2011	2012
CHANGES IN SPENDING SUBJECT TO APPROPRIATION [a]					
Estimated Authorization Level	2,178	2,122	2,186	2,216	2,251
Estimated Outlays	1,385	2,190	2,355	2,347	2,293
CHANGES IN DIRECT SPENDING [b,c]					
Estimated Budgetary Authority	*	*	*	*	*
Estimated Outlays	*	*	*	*	*

Note: * = less than $500,000.

[a] This table does not include the costs for implementing sections 401 and 404 of S. 1233, which CBO cannot estimate.

[b] In addition to the direct spending effects shown here, enacting S. 1233 would have additional effects on direct spending after 2012. The estimated increase in direct spending would total $1 million over the 2008–2012 period and $3 million over the 2008–2017 period.

[c] Numbers may not add up to totals in text because of rounding.

Basis of estimate: For this estimate, CBO assumes that the legislation will be enacted near the start of fiscal year 2008, that the estimated amounts will be appropriated each year, and that outlays will follow historical spending patterns for the VA medical services and major construction programs.

Spending subject to appropriation

S. 1233 would create new programs to treat traumatic brain injury for combat veterans, authorize the construction of hospitals for the Department of Veterans Affairs, and expand health care benefits for certain veterans, especially for those without disabilities connected to military service. It also would change the rules for funding service agencies which provide assistance to homeless veterans, the cost of which CBO cannot estimate because neither VA nor CBO can predict how the hundreds of service agencies would alter their requests for VA funding. (We expect those costs would probably be in the tens of millions of dollars per year.) CBO estimates that implementing the remainder of S. 1233 would result in discretionary outlays of about $1.4 billion in 2008 and $10.6 billion over the 2008–2012 period (see Table 2).

Enrollment for Priority 8 Veterans. Veterans enrolling in the VA health care system are assigned to one of eight priority care groups, based on such factors as disability rating and income. Each year the Secretary of Veterans Affairs announces which enrollment categories of veterans will be eligible to receive VA health care in the following year. That determination is based on an estimate of health care costs and available resources. Once enrolled, however, veterans are not excluded, regardless of enrollment category.

Since January 2003, VA has not accepted new enrollments of priority 8 veterans—veterans without a service-connected disability and with incomes above certain thresholds—and VA has announced that the ban on enrollment of category 8 veterans will continue through 2008. Section 301 would void that exclusion for 2008. Section 302 would codify the Secretary's responsibility to announce the annual enrollment decision in the Federal Register and require the simultaneous submission of a report on that decision to the Congress. Based on VA's repeated determinations to exclude priority 8 veterans, CBO expects that the effect of these two sections would be the enrollment of priority 8 veterans during 2008 only. (Because the bill's provision to void an exclusion for 2008 applies

only to that year, we expect that enrollment of new priority 8 veterans would not continue after 2008 under this bill.)

Based on data from VA about the projected population of potential priority 8 enrollees and the cost of current priority 8 enrollees, CBO estimates that implementing section 301 would allow about 1.3 million new priority 8 veterans to enroll in the VA health care program at an average annual net cost of about $1,400 in 2008. (The net cost equals the cost of care minus copayments and third-party reimbursements.) After adjusting for expected inflation, CBO estimates that implementing this provision would increase VA health care costs by $1.2 billion in 2008 and almost $8.8 billion over the 2008–2012 period, assuming appropriation of the necessary amounts.

Increase in Veterans' Travel Benefits. Section 307 would increase the travel allowance available to certain veterans for medical or vocational rehabilitation appointments. Veterans with a low income and veterans seeking treatment for a service-related disability are currently eligible to receive 11 cents per mile traveled for medical appointments at VA facilities, with a $3 deductible each way. Those traveling for a disability rating examination receive 17 cents per mile with no deductible. Those travel reimbursements are discretionary costs and are covered in this part of the estimate. (Travel reimbursements for vocational rehabilitation appointments are classified as mandatory spending, and those costs are discussed later in the "Direct Spending" section.)

Current law calls for the $3 deductible to increase proportionately with any increase in the mileage reimbursement rate. Section 307 would freeze the deductible at $3 and link the mileage reimbursement rate to that used by the federal government to reimburse employees for work-related travel in their personal vehicles when government vehicles are available for their use. That rate is currently 28.5 cents per mile. In 2006, VA spent about $55 million to reimburse veterans for travel to medical appointments and about $5 million in travel reimbursements for veterans traveling for disability rating examinations. Based on information from VA, CBO estimates that, in 2008, increasing the mileage rates and freezing the deductible for medical appointments would require the appropriation of $113 million in that year. That cost reflects CBO's expectation that increasing the mileage rate also would increase the number claims for travel reimbursement by 10 percent. Assuming that mileage reimbursement rates would increase by about 2 percent each year, CBO estimates that implementing this section would cost about $750 million over the 2008–2012 period, assuming the appropriation of the necessary amounts.

Table 2. Components of Discretionary Spending Under S. 1233 [a,b]

	By fiscal year, in millions of dollars—				
	2008	2009	2010	2011	2012
Enrollment for Priority 8 Veterans:					
Estimated Authorization Level	1,363	1,866	1,916	1,966	2,015
Estimated Outlays	1,192	1,771	1,884	1,946	1,997
Increase in Veterans' Travel Benefits:					
Estimated Authorization Level	113	155	158	162	165
Estimated Outlays	102	153	156	160	164

Table 2. Components of Discretionary Spending Under S. 1233 [a,b]—Continued

	By fiscal year, in millions of dollars—				
	2008	2009	2010	2011	2012
Major Medical Facility Projects:					
Authorization Level	627	0	0	0	0
Estimated Outlays	28	169	204	151	57
Health Professionals Scholarship Program:					
Estimated Authorization Level	12	25	27	28	15
Estimated Outlays	11	24	27	28	16
Extending Time for Preferred Health Care:					
Estimated Authorization Level	10	20	25	25	25
Estimated Outlays	9	19	24	25	25
Help for Very-Low-Income Veterans:					
Authorization Level	16	21	26	0	0
Estimated Outlays	14	20	25	2	*
Traumatic Brain Injury Program:					
Authorization Level	10	10	10	10	10
Estimated Outlays	9	10	10	10	10
Assisted Living Pilot Program:					
Authorization Level	8	8	8	8	8
Estimated Outlays	7	8	8	8	8
Rural Veterans Transportation:					
Authorization Level	6	6	6	6	6
Estimated Outlays	5	6	6	6	6
Copayments for the Catastrophically Disabled:					
Estimated Authorization Level	6	6	6	6	6
Estimated Outlays	6	6	6	6	6
Veterans Released from Prison:					
Estimated Authorization Level	4	4	4	4	0
Estimated Outlays	1	3	4	4	3
Homeless Demonstration Program:					
Authorization Level	2	0	0	0	0
Estimated Outlays	1	*	*	*	0
Total Changes:					
Estimated Authorization Level	2,178	2,122	2,186	2,216	2,251
Estimated Outlays	1,385	2,190	2,355	2,347	2,293

Note: * = less than $500,000.
[a] This table does not include the costs of implementing sections 401 and 404 of S. 1233, which CBO cannot estimate.
[b] Numbers may not add up to totals because of rounding.

Major Medical Facility Projects. Sections 501 through 503 would authorize work on three medical facility projects. CBO estimates that implementing those sections would cost $28 million in 2008 and $609 million over the 2008–2012 period, assuming appropriation of the necessary amounts.

Section 501 would authorize VA to replace the medical center in Denver. The bill would authorize the appropriation of $548 million in 2008 for this project. Section 501 also would authorize VA to spend any unobligated amounts in the major construction account on the Denver medical center. Based on information from VA, CBO does not expect that funding in excess of that which is specifically appropriated for the project will be needed.

Section 502 would authorize the appropriation of $59 million in 2008 for the consolidation of medical centers in Pittsburgh.

Section 503 would authorize the appropriation of $21 million in 2008 for the modernization of inpatient wards at the medical center in Atlanta.

Health Professionals Scholarship Program. Section 601 would revive a health professionals scholarship program that expired in 1998. The provision would give VA the authority to provide funds

to cover tuition, fees, the costs of books and laboratory equipment, and a stipend for students in certain medical or nursing school programs, such as general medicine, dentistry, or psychology. The scholarships could be from one to four years, though preference would be given to students in their last year of school. In exchange for financial assistance, recipients would be obligated to work at VA for a specified period of time.

Based on information from VA, CBO estimates that under S. 1233 VA would grant about 250 awards each year with an average award of $46,000 in 2008. Estimating an average scholarship of two years, and taking in to account an estimated 6 percent increase in tuition and other costs each year, CBO estimates that implementing this provision would cost $11 million in 2008 and $106 million over the 2008–2012 period, assuming the availability of appropriated funds.

Extending Time for Preferred Health Care. Under current law, veterans entering the VA health care system who have served in combat zones are automatically placed in priority category 6 until they receive a rating for a service-connected disability or until two years from the date of their discharge from active duty. Those who are determined to have a service-connected disability are reassigned to the highest priority categories—1, 2, or 3. At the end of the two-year period, all others are moved to the lowest priority categories—7 or 8—depending on their level of income. Veterans in those lowest two categories generally pay higher copayments for treatments and medications than veterans in the higher priority categories.

Section 201 would extend the period during which combat veterans can receive care in priority category 6—from the current two years from their date of discharge to five years. Thus, under this bill, veterans currently in category 6 would be allowed to remain at that priority level for an extra three years. Veterans who had already been reassigned to category 7 or 8, but had been discharged within the last five years, would be returned to category 6 for whatever remained of that five-year period. And combat veterans who had not yet sought care from VA would have up to three additional years to enter the health care system.

CBO estimates that enacting this provision would cause about 4,500 new combat veterans to enroll in the VA health care program in 2008, and 9,000 to enroll in 2009. Thereafter, however, CBO estimates that only a few hundred would enter each year and receive the additional benefit, as the number of combat veterans being discharged from active duty is expected to decline. Based on information from VA, CBO estimates that the cost of treating those additional veterans would be about $12 million in 2008, but that those same veterans would pay VA an additional $2 million that year in copayments. (For injuries or illnesses that are obviously not service-connected, such as those from a recent car accident or a bout with the flu, VA charges copayments.) Over the 2008–2012 period, CBO estimates that treatment of those veterans would increase costs by $120 million. During this same period, CBO estimates VA would receive additional copayments of about $25 million, which reduce the net level of appropriations necessary for health care.

CBO also estimates that, under this provision, VA would lose about $1 million each year in copayments from veterans who would be in priority category 6 rather than priority category 7 or 8. Veterans in the lowest two categories have no service-connected conditions and are charged copayments for all treatments. When veterans in priority category 6 seek treatment, their medical condition is assumed to be related to their military service—unless that is obviously not the case—and as a result, they are not charged copayments for those treatments. Thus, CBO estimates the total net cost of implementing section 201 would be about $10 million in 2008 and about $100 million over the 2008–2012 period, assuming appropriation of the necessary amounts.

Help for Very-Low-Income Veterans. Section 406 would authorize the appropriation of a total of $63 million over three years to provide financial assistance to qualified nonprofit organizations and consumer cooperatives that provide supportive services to very-low income veterans who live in permanent housing, with preference given to those entities that help veterans make a transition from homelessness to permanent housing. Very-low-income veterans would be defined as those having an income that is less than half of the median income for the area in which the veteran lives. The authorized funding would support a wide array of services, including outreach, health care, counseling, transportation, assistance with daily living, and assistance in obtaining veterans benefits and other public benefits, among others. It also would support technical assistance from VA to the nonprofit organizations for the planning and provision of services to veterans. CBO estimates that implementing this section would cost $14 million in 2008 and $63 million over the 2008–2012 period.

Traumatic Brain Injury Program. Section 104 would require VA to establish a program to provide neurologic rehabilitation to veterans with severe traumatic brain injury. The program would include research, education, and clinical care and would be done in collaboration with the Defense and Veterans Brain Injury Center—a program funded by the Department of Defense and operated in conjunction with VA and a private neuro-care center in Virginia. Section 104 would authorize the appropriation of $10 million each year from 2008 through 2012 to carry out this program. CBO estimates that implementing this provision would cost $9 million in 2008 and $49 million over the 2008–2012 period.

Assisted Living Pilot Program. Section 105 would require VA to carry out a five-year pilot program in at least four parts of the country to provide assisted living services to enhance the rehabilitation, quality of life, and community integration of veterans with traumatic brain injury. S. 1233 would authorize the appropriation of $8 million each year from 2008 through 2013 to implement and run the pilot program. CBO estimates that section 105 would cost $7 million in 2008 and $39 million over the 2008–2012 period.

Rural Veterans Transportation. Section 304 would authorize the appropriation of $6 million each year from 2008 through 2012 to provide grants to organizations that would assist veterans in rural areas to travel to VA medical facilities. Eligible entities would include state veterans agencies and nonprofit organizations. CBO estimates that implementing this section would cost $5 million in 2008 and $29 million over the 2008–2012 period.

Copayments for the Catastrophically Disabled. Section 303 would prohibit the collection of copayments and other fees from catastrophically disabled veterans who receive medical or nursing home care from VA. Data from VA shows that the Department collected about $6 million in medical care and nursing home fees in 2006 from catastrophically disabled veterans, who are priority category 4 veterans because their disabilities are not related to military service. Because those copayments and fees are not linked to any inflation index and the population of those veterans has been relatively stable over the last several years, CBO estimates that implementing this provision would decrease collections by $6 million per year. Such collections are offsets to discretionary appropriations. As part of the annual appropriations process, the Congress gives VA authority to spend those collections. Therefore, maintaining the same level of health care services for veterans would necessitate additional funding each year to make up for the loss of copayments under this bill. Thus, implementing section 303 would cost $6 million in 2008 and $30 million over the 2008–2012 period.

Veterans Released From Prison. VA is currently working with the Department of Labor (DOL) on a demonstration program to provide counseling and referrals to veterans leaving penal institutions who are at risk of becoming homeless. VA hires case managers to oversee the program while DOL administers the grants to nonprofit organizations that provide the counseling and referrals. Under current law, the program is being conducted at six sites and will expire on September 30, 2007. Section 403 would double the number of program sites and extend the authority through fiscal year 2011. CBO estimates that, in total, implementing this provision would cost about $1 million in 2008 and $15 million over the 2008–2012 period.

Based on information from VA that six case managers would be needed to oversee the 12 sites at an average cost of $80,000 per person, CBO estimates that such additional staff would cost VA less than $500,000 in 2008 and $2 million over the 2008–2012 period.

Under this program, DOL issued grants totaling over $1.6 million in 2007 through nonprofit organizations to provide counseling and referral services to almost 1,000 veterans leaving penal institutions. CBO estimates that increasing the size of the program would increase costs for such grants by less than $500,000 in 2008 and by $13 million over the 2008–2012 period.

Homeless Demonstration Program. Section 402 would require VA to develop and implement a demonstration program to identify active-duty servicemembers who are at risk of becoming homeless after being discharged from the military and to provide referrals, counseling, and other supportive services to help prevent their homelessness. The program would have to be carried out in at least three locations and would expire at the end of September 2011. Section 402 would authorize the appropriation of $2 million for the program. CBO estimates that implementing section 402 would cost $1 million in 2008 and $2 million over the 2008–2012 period.

Hospice Copayments. Section 309 would prohibit VA from collecting copayments from veterans receiving hospice care. This prohibition would apply to care received at both inpatient and outpatient facilities. Depending upon where veterans get hospice care,

copayments range from $15 per day to a maximum of $97 per day. Most veterans receiving this type of care from VA are not charged copayments—only veterans whose disabilities are unrelated to their military service and whose incomes are above a certain level are required to make copayments.

Based on information from VA that fewer than 450 veterans made copayments averaging about $800 last year for hospice care, CBO estimates that implementing this provision would decrease collections by less than $500,000 each year and by about $2 million over the 2008–2012 period. Those collections are funding offsets to discretionary appropriations. As part of the annual appropriations process, the Congress gives VA authority to spend those collections. Therefore, maintaining the same level of health care services for veterans would necessitate additional funding each year to make up for the loss of copayments under this bill. Therefore, implementing section 309 would cost less than $500,000 in 2008 and about $2 million over the 2008–2012 period.

Homeless Providers Grant and Per Diem Program (GPD). VA's Homeless Providers Grant and Per Diem Program funds community-based agencies providing services to homeless veterans. The GPD provides two levels of funding—capital grants and per diem payments. Capital grants can provide up to 65 percent of the cost of establishing or expanding a community program offering transitional housing assistance, meals, vocational counseling and training, and other related services to homeless veterans. Capital grants may not be used for salaries or other operational costs. GPD provided about $5 million in capital grants in 2006.

Community agencies are also eligible for per diem payments, which fund operational costs. Per diem payment rates reflect the daily cost of services furnished to eligible veterans, but are reduced by the amounts of payments for similar purposes from other governmental agencies or private organizations. GPD distributed about $59 million in per diem payments to about 300 agencies in 2006. The program has received funding of $92 million for grants and payments in 2007.

Section 404 would allow capital grants to be used to pay staff salaries, thus potentially increasing the dollar amount of the grants community agencies would be eligible to receive. In addition, section 401 would require that per diem payments not be reduced by the amounts of payments from other organizations. Based on the current usage of the grant and per diem program, CBO expects that implementing sections 401 and 404 would probably increase discretionary outlays for capital grants and per diem payments by tens of millions of dollars a year. CBO cannot provide a more specific estimate because neither VA nor CBO can predict how the many community agencies would alter their requests for VA funding under these provisions.

Other Provisions. There are several sections in S. 1233 that would have an insignificant impact on discretionary spending. These provisions would require reports or plans or would authorize VA to do something it is already doing or planning to do, such as providing ageappropriate nursing home care or conducting research on traumatic brain injuries. Other sections that would have an insignificant impact on discretionary spending include:

• Section 203 would require VA to aggregate information from various sources on the quality of its medical centers and provide this information to the public on the Internet or through promotional literature.
• Section 204 would require VA to provide a mental health evaluation for certain war veterans within 30 days of receiving a request.
• Section 305 would require VA to establish a demonstration project to examine alternatives for expanding care for veterans in rural areas.
• Section 505 would designate a medical center in Augusta, Georgia, the "Charlie Norwood Department of Veterans Affairs Medical Center."

Direct spending

Section 307 would increase the mileage rate used to reimburse certain veterans for travel to and from some appointments at VA facilities. (For more details on the travel benefits program and an estimate of the discretionary costs for implementing this provision, see the discussion under "Spending Subject to Appropriation.") Veterans who travel to a required appointment to receive counseling and evaluation before beginning vocational rehabilitation are reimbursed at 17 cents per mile. This section would link the veterans' mileage payment rate to the rate used by the federal government when reimbursing employees who travel in their personal vehicles for business when government vehicles are available for their use. That rate is currently 28.5 cents per mile and is increased at intervals to account for inflation.

VA reports that it spends about $400,000 per year to reimburse veterans for traveling to appointments for vocational rehabilitation, which is a mandatory program. Increasing the mileage rate under this provision would increase spending by $1 million over the 2008–2012 period and $3 million over the 2008–2017 period.

Intergovernmental and private-sector impact: S. 1233 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act. State, local, and tribal governments that participate in programs to assist disabled or homeless veterans would benefit from research and new programs authorized in the bill. Any costs they might incur would result from complying with conditions of federal assistance.

Previous CBO estimates: On May 21, 2007, CBO transmitted a cost estimate for H.R. 612, the Returning Servicemember VA Healthcare Insurance Act of 2007, as ordered reported by the House Committee on Veterans' Affairs on May 15, 2007. Section 201 of S. 1233 is similar to H.R. 612, though it would not extend the benefit to those whose period of priority health care has already expired. Therefore, the estimated cost for section 201 is less than the cost for H.R. 612.

On July 24, 2007, CBO transmitted a cost estimate for H.R. 2623, a bill to amend title 38, United States Code, to prohibit the collection of copayments for all hospice care furnished by the Department of Veterans Affairs, as ordered reported by the House Committee on Veterans' Affairs on July 17, 2007. That bill would prohibit the collection of copayments for hospice care furnished by

VA. Section 309 of S. 1233 is similar to H.R. 2623 and the estimated costs are the same.

On July 27, 2007, CBO transmitted a cost estimate for H.R. 2874, the Veterans' Health Care Improvement Act of 2007, as ordered reported by the House Committee on Veterans' Affairs on July 17, 2007. Sections 304, 403, and 406 of S. 1233 are similar to provisions found in H.R. 2874. Section 406 of S. 1233 and section 9 of H.R. 2874 would provide funding to organizations that help very-low-income veterans, though each bill would authorize appropriations of different amounts each year for the new program. Section 304 of S. 1233 and section 3 of H.R. 2874 would establish grants for organizations that provide transportation to veterans in rural areas in need of medical care, though S. 1233 would authorize a higher amount of funding. Section 403 of S. 1233 and section 7 of H.R. 2874 would expand a program to help veterans leaving penal institutions. Differences in the estimated costs for these provisions reflect differences in the bills.

On August 21, 2007, CBO transmitted a revised cost estimate for H.R. 760, the Filipino Veterans Equity Act of 2007, as ordered reported by the House Committee on Veterans' Affairs on July 18, 2007. Both section 5 of H.R. 760 and section 307 of S. 1233 would increase the milage rate of the travel benefit for veterans receiving certain kinds of care. However, the increase under H.R. 760 would be more generous than under S. 1233. The provision in H.R. 760 would eliminate the deductible while the one in S. 1233 would only freeze the deductible. The estimated costs of the two provisions differ for those reasons.

Estimate prepared by: Federal Costs: Michelle S. Patterson (226–2840); Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum (225–3220); Impact on the Private Sector: Victoria Liu (226–2900).

Estimate approved by: Peter H. Fontaine, Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact that would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by Members of the Committee on Veterans' Affairs at its June 27, 2007 meeting. On that date, the Committee ordered S. 1233 reported favorably to the Senate, by voice vote.

On that date, the Committee considered the Craig amendment on Priority 8 veterans, to modify the underlying statute by requiring Secretarial certification prior to any change to enrollment that enrollment of Priority 8 veterans will not have a detrimental effect

on access to and quality of care provided to veterans, and that the Department has sufficient staff, facilities, and equipment to provide quality care to all enrolled veterans. The Craig amendment was defeated by a 5 to 10 vote.

Yeas	Senator	Nays
	Mr. Rockefeller	X
	Ms. Murray	X
	Mr. Obama	X PROXY
	Mr. Sanders	X
	Mr. Brown	X PROXY
	Mr. Webb	X PROXY
	Mr. Tester	X
X	Mr. Craig	
	Mr. Specter	X PROXY
X	Mr. Burr	
	Mr. Isakson	X
X PROXY	Mr. Graham	
X PROXY	Ms. Hutchison	
X PROXY	Mr. Ensign	
	Mr. Chairman	X
5	TALLY	10

SUPPLEMENTAL VIEWS OF HON. LARRY E. CRAIG, RANKING MEMBER, SENATE VETERANS' AFFAIRS COMMITTEE

The underlying legislation provides many important provisions that will improve the health care services and benefits available to America's veterans. I am particularly pleased that Title I takes many important steps towards improving the care provided to those veterans suffering with a traumatic brain injury.

However, in a few areas, I believe the legislation not only fails to improve the current benefits and health care system available for veterans, it in fact dilutes certain benefits available for service-connected veterans and may undermine the access and quality of care provided to the current users of VA's health care system.

Let me explain my concerns.

REPEAL OF THE REGULATION CONCERNING THE ENROLLMENT OF PRIORITY 8 VETERANS

The underlying legislation repeals a regulation issued by former Secretary of Veterans Affairs, Anthony J. Principi, concerning enrollment priorities. That regulation prohibited enrollment into VA's health care system by any veteran in Priority 8 status who had not enrolled prior to January 17, 2003. At the time Secretary Principi announced the new regulation, a VA news release stated:

> VA has been unable to provide all enrolled veterans with timely access to health care services because of the tremendous growth in the number of veterans seeking VA health care. . . .
>
> In order to ensure VA has capacity to care for veterans for whom our Nation has the greatest obligation—[those with] military-related disabilities, lower-income veterans or those needing specialized care like veterans who are blind or have spinal cord injuries—Principi has suspended additional enrollments for veterans with the lowest statutory priority. This category includes veterans who are not being compensated for a military-related disability and who have higher incomes.

Since that decision was rendered, many Veterans Service Organizations and individual veterans have advocated re-opening the health care system to all veterans. However, none has advocated abolishing the priority system developed under the Eligibility Reform Act of 1996, which was the basis for Principi's decision in 2003. Continuing that trend, the underlying bill does not repeal the eligibility prioritization structure created under the 1996 law.

Given that the statutory priorities for health care enrollment still exist, it would be reasonable to presume that the majority had made a determination that VA was now providing all currently enrolled veterans with timely access to quality health care. And

therefore the conditions which drove Secretary Principi's earlier decision (an inability to provide enrolled veterans with timely access to health care services) no longer existed. The record, however, does not suggest that such a conclusion has been reached by the majority.

Instead, the record shows many Senators expressing concerns about servicemembers returning from Iraq and Afghanistan facing—what are often described as—lengthy waiting times for care. In the face of such assessments, I do not understand how the majority could suggest that opening up the health care system to hundreds-of-thousands—if not millions—of new patients is wise policy.

Moreover, it appears that the provision in this bill would open VA to new enrollees on the day the legislation is signed into law. There is no plan required to ensure that the enrollment process would be orderly and executed in a way that would minimize its effect on current patients. Nor is there any requirement that the necessary funding be available prior to its implementation. Instead, VA would simply open the doors and wait to see who arrives. I believe that is irresponsible and unfair to the current enrollees.

That is not just my view. Rather, my opinion echoes that of the Disabled American Veterans who, while commenting on the issue of re-opening VA to priority 8's, stated that "without a major infusion of new funding, enactment of this bill [S. 1147] would worsen VA's financial situation, not improve it, and would likely have a negative impact on the system as a whole."

To address my concerns, I offered an amendment during the Committee's consideration of the legislation. My amendment would have required Secretarial certification of three facts prior to enrollment being deemed "open."

First, the Secretary would have had to certify that quality of care and access thereto for enrolled veterans in Priority groups 1–6 would not be adversely affected by the newer patients. Because current law treats those veterans as a higher priority, I believe that VA must demonstrate conclusively that it is already offering high quality, timely care to our service-connected and lower income veterans. As I've already stated, recent observations and statements by some Senators suggest otherwise.

Second, the Secretary would have had to certify that troops returning from Iraq and Afghanistan were provided timely, high quality health care already and that such timeliness and quality would not suffer because of newer enrollees. In my view, VA's health care system was created primarily for the purpose of caring for "he who shall have borne the battle." Congress should ensure that this unique group of veterans is not unduly burdened by any new influx of higher income veterans with no military-related disabilities.

Finally, my amendment would have required that the Secretary certify to Congress that VA had the capability to see a large influx of new patients. My amendment asked for an assessment as to whether VA had the physical infrastructure, human resources, and medical equipment to treat any new influx of veterans.

I recognize that many Senators believe that money is the only obstacle to providing all veterans with health care through VA.

However, any money provided for new patients would be used to buy new staff, new equipment, and new space. Therefore, I felt it was important to know whether each of those three goods or services was possible to obtain.

The issue of whether VA has the capability to hire new staff alone should give any Senator pause in supporting the expansion in this legislation. It is widely known that the Nation is struggling to provide a stable supply of primary care physicians and nurses to provide basic health care services in non-VA facilities. This issue was made clear in a July 2007 report from the Health Research Institute of PricewaterhouseCoopers which showed that the United States will be short nearly one million nurses and 24,000 physicians by 2020. In that environment, simply finding new staff to hire will be a challenge for any health care system, including VA.

Further, assuming the requisite staff can be found, I remain skeptical that VA has the necessary clinical space in which to provide more primary and specialty care services. I am also equally skeptical that many VA facilities could open the additional operating rooms, post-surgical recovery units, and intensive care units that would be required with a large increase in patients.

My amendment failed in Committee. Still, while the answers to the questions may not be required by law prior to opening the health care system to all veterans, I continue to believe it would be a mistake to proceed without the knowledge set forth in my amendment. As such, I oppose Section 301 of the bill.

REPEAL OF INPATIENT COPAYMENT REQUIREMENT ON PRIORITY 4 VETERANS

The underlying legislation also contains a provision waiving required inpatient care copayments for Priority 4 veterans with higher incomes. I have concerns with this provision as well.

Under current law, veterans rated at 50 percent or more service-connected disabled do not pay copayments for medical care. In addition, VA charges no copayment if the care provided is for the treatment of a service-connected condition. Veterans classified as Priority 4, by definition, have no service-related disabilities. Finally, there is no medical copayment charged if the veteran qualifies as a Priority 5 due to limited financial resources.

It is important to note that Priority 5 qualification does not mean one must be placed in Priority 5 in order to qualify for cost-free care. For example, a veteran with a 10 percent disability rating would be placed in Priority group 3 under the current system. As noted above, the veteran would pay no copayments for the treatment of his or her service-connected disability. If the same veteran had an income level that would place him or her in Priority 5 if not for the 10 percent rating, then VA would charge no copayment to the veteran when he or she receives care for non-service-connected conditions. Otherwise, the veteran would pay copayments for non-service-connected care.

This same analysis applies to Priority 4 veterans who would be Priority 5 if not for the catastrophic disability. As such, the provision in this bill relieves only higher income Priority 4 veterans from the copayment requirement.

The problem I have is that with passage of this provision, VA will have a policy of charging service-connected disabled veterans with higher incomes a copayment for the care of a non-service-connected condition. But, VA will not charge higher income veterans for the treatment of non-service-connected conditions if the veteran is catastrophically disabled.

I recognize that veterans with catastrophic disabilities face innumerable challenges each and everyday. In fact, it is for this reason that I strongly support the current law which provides premium-free access to VA's health care system, including its nationally recognized spinal cord injury and blind rehabilitation programs to those afflicted with a catastrophic impairment. Still, I believe there must be reasonable lines drawn in the allocation of VA's benefits. I believe a copayment is that reasonable line.

A grateful nation has seen fit to provide cost-free care for service-connected conditions. And a generous nation has extended the same benefit to those with limited economic means. Unfortunately, with this provision, it is no longer relevant to this Committee whether one can afford to contribute even modestly to the cost of their care. Rather, cost-free care is now provided to a population of patients based solely their health status. That is a bad precedent.

If this legislation passes, I believe that in the not too distant future, it will be strongly argued by higher income, service-connected veterans that their benefit (cost free care for service-connected conditions) has been diluted. And the dilution is not fair because now they are charged for non-service-connected care when those with similar economic means in Priority 4 are not forced to make copayments for the same type of care. With this provision as precedent, a future Congress will be forced to concede to the dilution and its unfairness. Then they will probably be forced to accede to the change.

For these reasons I oppose Section 303 of the bill.

RURAL TRANSPORTATION GRANT PROGRAM

The underlying bill also contains a provision that would create a VA rural transportation grant program. Under the plan, VA is authorized to spend up to $6 million per year for five years providing grants of up to $50,000 to: State veterans' service agencies; veterans' service organizations; or qualified community transportation organizations. The legislation does not require the recipient to provide any matching funds.

As a Senator from a largely rural State, I fully understand the challenges facing veterans (and others) who live in remote areas far from health care providers. However, I simply cannot defend the creation of an entire rural transportation system dedicated solely to providing transportation to veterans as a remedy to that problem.

First, a transportation program, such as the one proposed in this bill, is well outside the boundaries of VA's basic mission of providing care and compensatory benefits to veterans of the Armed Forces. In fact, it is so far from VA's mission, that Congress has created an entirely separate federal agency—the U.S. Department of Transportation—to undertake that mission for the public at

large. If an entirely new transportation program is warranted, I believe managing the creation of the new program belongs with the Department of Transportation.

Second, while transportation is not VA's mission, that does not mean Congress has not recognized that it is an element necessary to consider when attempting to provide health care to veterans. As such, Congress has created a mileage reimbursement program for service-connected disabled veterans, which reimbursement rate this legislation raises.

Further, VA and Congress strongly and actively support the volunteer van program operated by the Disabled American Veterans. Under the van program, DAV has donated over 1,800 vans to VA at a cost of $20 million. Further, the organization has matched those vans with nearly $40 million in volunteer driver services. VA's ownership of the vans helps address difficult insurance questions and the voluntary nature of the program helps to ensure the program's benevolent purpose—helping veterans—remains its focus.

I fear that the program created under this legislation will ultimately undermine the charitable endeavor represented by DAV's van program.

For these reasons I oppose Section 304 of this bill.

CHANGES IN EXISTING LAW MADE BY THE COMMITTEE BILL, AS REPORTED

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, changes in existing law made by the Committee bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38—VETERANS' BENEFITS

PART I—GENERAL PROVISIONS

CHAPTER 1—GENERAL

SEC. 101. DEFINITIONS.

* * * * * * *

(34) The term 'Post 9/11 Global Operations' means the period of the Persian Gulf War beginning on September 11, 2001, and ending on the date thereafter prescribed by Presidential proclamation or by law.

* * * * * * *

SEC. 111. PAYMENTS OR ALLOWANCES FOR BENEFICIARY TRAVEL.

* * * * * * *

(c)(1) * * *

(2) In the case of a person who is determined by the Secretary to be a person who is required to make six or more one-way trips for needed examination, treatment, or care during the remainder of the calendar month in which the determination is made or during any subsequent calendar month during the one-year period following the last day of the month in which the determination is made, the amount deducted by the Secretary pursuant to paragraph (1) of this subsection from payments for trips made to or from such facility during any such month shall not **[**, except as provided in paragraph (5) of this subsection,**]** exceed $18.

* * * * * * *

[(5) Whenever the Secretary increases or decreases the rates of allowances or reimbursement to be paid under this section, the Secretary shall, effective on the date on which such increase or decrease takes effect, adjust proportionately the dollar amounts specified in paragraphs (1) and (2) of this subsection as such amounts may have been increased or decreased pursuant to this paragraph before such date.**]**

* * * * * * *

(g)(1) [In carrying out the purposes of this section, the Secretary, in consultation with the Administrator of General Services, the Secretary of Transportation, the Comptroller General of the United States, and representatives of organizations of veterans, shall conduct periodic investigations of the actual cost of travel (including lodging and subsistence) to beneficiaries while traveling to or from a Department facility or other place pursuant to the provisions of this section, and the estimated cost of alternative modes of travel, including public transportation and the operation of privately owned vehicles. The Secretary shall conduct such investigations immediately following any alteration in the rates described in paragraph (3)(C) of this subsection, and, in any event, immediately following the enactment of this subsection and not less often than annually thereafter, and based thereon, shall determine rates of allowances or reimbursement to be paid under this section.] *Subject to paragraph (3), in determining the amount of allowances or reimbursement to be paid under this section, the Secretary shall use the mileage reimbursement rate for the use of privately owned vehicles by Government employees on official business (when a Government vehicle is available), as prescribed by the Administrator of General Services under section 5707(b) of title 5.*

* * * * * * *

(3) Subject to the availability of appropriations, the Secretary may modify the amount of allowances or reimbursement to be paid under this section using a mileage reimbursement rate in excess of that prescribed under paragraph (1).

[(3) In conducting investigations and determining rates under this section, the Secretary shall review and analyze, among other factors, the following factors:

[(A)(i) Depreciation of original vehicle costs;

[(ii) gasoline and oil costs;

[(iii) maintenance, accessories, parts, and tire costs;

[(iv) insurance costs; and

[(v) State and Federal taxes.

[(B) The availability of and time required for public transportation.

[(C) The per diem rates, mileage allowances, and expenses of travel authorized under sections 5702 and 5704 of title 5 for employees of the United States.]

[(4) Before determining rates or adjusting amounts under this section and not later than sixty days after any alteration in the rates described in paragraph (3)(C) of this subsection, the Secretary shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing the rates and amounts the Secretary proposes to establish or continue with a full justification therefor in terms of each of the limitations and factors set forth in this section.]

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CHAPTER 5—AUTHORITY AND DUTIES OF THE SECRETARY

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Sec.

Subchapter II—Specified Functions

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SEC. 530A. REPORT ON VETERANS AND THE PROVISION TO VETERANS OF BENEFITS AND SERVICES BY THE DEPARTMENT.

(a) ANNUAL REPORT REQUIRED.—(1) Not later than 90 days after the end of the fiscal year in which this section is enacted and every fiscal year thereafter, the Secretary shall submit to the appropriate committees of Congress a report on veterans and the provision to veterans of benefits and services under the laws administered by the Secretary.

(2) Each report required by paragraph (1) shall provide the information specified in subsection (c), current as of the last day of the fiscal year for which the report is submitted.

(b) QUARTERLY REPORT REQUIRED.—(1) Not later than 60 days after the end of the first quarter following the date on which this section is enacted and quarterly thereafter, the Secretary shall submit to the appropriate committees of Congress a report on the claims of veterans for service-connected compensation under section 1114 of this title.

(2) Each report required by paragraph (1) shall provide the information specified in subparagraphs (A) and (F) of subsection (c)(2), current as of the last day of the quarter for which the report is submitted.

(c) COVERED INFORMATION.—The information specified in this subsection for a report under subsection (a) is information on veterans and the provision to veterans of benefits and services under the laws administered by the Secretary as follows:

(1) For each covered tour of duty category, aggregated personal information on veterans provided benefits and services under the laws administered by the Secretary, including demographic information as follows:

(A) Sex.

(B) Age.

(C) Marital status (whether married, single, separated, or divorced).

(D) Residence (by State, territory, or country).

(E) Armed Force, as of the date of discharge or separation.

(F) Service as a member of a regular component of the Armed Forces or as a Reserve (including whether National Guard or Reserve).

(G) Separation status.

(2) For each covered tour of duty category, aggregated information on the compensation, pension, and other benefits and services provided by the Department to veterans, or provided

with respect to such veterans as the case may be, including the following:

(A) The claims of such veterans for service-connected compensation under section 1114 of this title, including the following set forth by:

(i) The number of such claims received.

(ii) The number of such claims processed.

(iii) The number of such claims pending.

(iv) The number of such claims granted.

(v) The number of such claims denied.

(vi) The number of such claims with a combined disability rating of 10 percent or more.

(B) The amount of such compensation paid to such veterans, stated as an average monthly amount of such veterans receiving such compensation set forth by the following:

(i) Such veterans with a disability rating of zero percent.

(ii) Such veterans with a disability rating of 10 percent.

(iii) Such veterans with a disability rating of 20 percent.

(iv) Such veterans with a disability rating of 30 percent.

(v) Such veterans with a disability rating of 40 percent.

(vi) Such veterans with a disability rating of 50 percent.

(vii) Such veterans with a disability rating of 60 percent.

(viii) Such veterans with a disability rating of 70 percent.

(ix) Such veterans with a disability rating of 80 percent.

(x) Such veterans with a disability rating of 90 percent.

(xi) Such veterans with a disability rating of 100 percent.

(xii) Such veterans paid special monthly compensation under any of subsections (k) through (s) of section 1114 of this title.

(C) The claims for dependency and indemnity compensation under chapter 13 of this title, with respect to such veterans, including the following:

(i) The number of such claims received.

(ii) The number of such claims processed.

(iii) The number of such claims pending.

(iv) The number of such claims granted.

(v) The number of such claims denied.

(D) The amount of such dependency and indemnity compensation paid with respect to survivors of such veterans, stated as an average monthly amount.

(E) The number of such survivors who have one or more dependent children under the age of 18 and who receive ad-

ditional benefits under section 1311(f) of this title by reason thereof.

(F) The claims for pension under chapter 15 of this title, for or with respect to such veterans, including the following:

(i) The number of such claims received.

(ii) The number of such claims processed.

(iii) The number of such claims pending.

(iv) The number of such claims granted.

(v) The number of such claims denied.

(G) The amount of such pension paid for or with respect to such veterans, stated as an average monthly amount set forth by whether such veterans have—

(i) no eligible dependents;

(ii) one or more dependents;

(iii) benefits paid at the house bound rate; and

(iv) benefits paid at the rate for aid and attendance.

(3) For each covered tour of duty category, aggregated information on the use of vet centers by veterans, including the number of veterans using services of vet centers set forth by whether such veterans are members of the National Guard or the Reserves.

(4) For each covered tour of duty category, aggregated information on the provision to veterans of health care services by the Veterans Health Administration, set forth by the following:

(A) Whether the services provided were inpatient or outpatient services.

(B) Aggregate information about such veterans served, including the number of such veterans set forth by the following:

(i) Sex.

(ii) Age.

(iii) Armed Force, as of the date of discharge or separation.

(iv) Service as a member of a regular component of the Armed Forces or as a Reserve (including whether National Guard or Reserve).

(C) Where such services were provided, including whether such services were provided in a hospital, vet center, or a specialty care facility such as a polytrauma center.

(5) For each covered tour of duty category, aggregated information on mental health disorders of veterans, including the number of veterans who after December 31, 2002, have been diagnosed or treated for one or more of the following:

(A) Post-traumatic stress disorder.

(B) Depressive disorders.

(C) Neurotic disorders.

(D) Substance use disorders.

(E) Acute reaction to stress.

(F) Such other mental disorders as the Secretary considers appropriate.

(d) PROTECTION OF IDENTITIES.—The Secretary shall take appropriate actions in preparing and submitting reports under this section to ensure that no personally identifying information on any

particular veteran is included or otherwise improperly released in such reports.

(e) DEFINITIONS.—In this section:

(1) The term 'appropriate committees of Congress' means—

(A) the Committees on Armed Services, Appropriations, and Veterans' Affairs of the Senate; and

(B) the Committees on Armed Services, Appropriations, and Veterans' Affairs of the House of Representatives.

(2) The term 'duty in the Post 9/11 Global Operations theater' means service in the active military, naval, or air service during the Post 9/11 Global Operations in a location (including the airspace above) as follows:

(A) Afghanistan.

(B) Iraq.

(C) Any geographic location specified for an award of the Global War on Terrorism Expeditionary Medal to members of the Armed Forces.

(3) The term 'covered tour of duty category' means the following:

(A) Deployment in only in Afghanistan.

(B) Deployment in only in Iraq.

(C) Deployment in both Afghanistan and Iraq.

(D) Duty in the Post 9/11 Global Operations theater other than in Afghanistan or Iraq.

(E) Any other duty not covered by subparagraphs (A) through (D).

(4) The term 'vet center' means a center for the provision of readjustment counseling and related mental health services under section 1712A of this title.

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PART II—GENERAL BENEFITS

CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

* * * * * * *

Sec.

* * * * * * *

Subchapter I—General

SEC. 1702. PRESUMPTION RELATING TO [PSYCHOSIS] *MENTAL ILLNESS*.

For the purposes of this chapter, any veteran of World War II, the Korean conflict, the Vietnam era, or the Persian Gulf War who developed an active [psychosis] *mental illness* (1) within two years after discharge or release from the active military, naval, or air

service, and (2) before July 26, 1949, in the case of a veteran of World War II, before February 1, 1957, in the case of a veteran of the Korean conflict, before May 8, 1977, in the case of a Vietnam era veteran, or before the end of the two-year period beginning on the last day of the Persian Gulf War, in the case of a veteran of the Persian Gulf War, shall be deemed to have incurred such disability in the active military, naval, or air service.

* * * * * * *

SEC. 1705. MANAGEMENT OF HEALTH CARE: PATIENT ENROLLMENT SYSTEM.

* * * * * * *

(d)(1) In operating the system of annual patient enrollment in accordance with subsection (a), the Secretary shall, not later than August 1 of each year, publish in the Federal Register notice of which categories of veterans the Secretary has determined will be eligible to be enrolled in the next fiscal year beginning after such publication.

(2)(A) If, in a notice published in accordance with paragraph (1), the Secretary proposes to restrict the categories of veterans to be eligible to be enrolled in the system of annual patient enrollment in a fiscal year, the Secretary shall, on the same date that such notice is published, submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report setting forth an estimate of the difference between—

(i) the cost to the Department in such fiscal year of enrolling in such system any veterans who would otherwise be enrolled if not for the operation of such restriction, and

(ii) the cost to the Department in such fiscal year of enrolling veterans as proposed by the Secretary in such notice.

(B) The Secretary may not implement any restriction on the categories of veterans eligible to be enrolled in a fiscal year until 45 days after the date on which the report on such restriction under subparagraph (A) is submitted under that subparagraph.

* * * * * * *

Subchapter II—Hospital, Nursing Home, Domiciliary Care and Medical Treatment

SEC. 1710. ELIGIBILITY FOR HOSPITAL, NURSING HOME, AND DOMICILIARY CARE

* * * * * * *

(a)(1) * * *

(4) The requirement in paragraphs (1) and (2) that the Secretary furnish hospital care and medical services, the requirement in section 1710A(a) of this title that the Secretary provide nursing home care, the requirement in section 1710B of this title that the Secretary provide a program of extended care services, *the requirement in section 1710D of this title that the Secretary provide certain intervention, rehabilitative treatment, or services,* and the requirement in section 1745 of this title to provide nursing home care and prescription medicines to veterans with service-connected disabilities in State homes shall be effective in any fiscal year only to the

extent and in the amount provided in advance in appropriations Acts for such purposes.

* * * * * * *

(e)(3) * * *

(C) in the case of care for a veteran described in paragraph(1)(D), after a period of [2 years] *5 years* beginning on the date of the veteran's discharge or release from active military, naval, or air service; and

* * * * * * *

(f)(1) * * *

(6) This subsection does not apply to hospital care or nursing home care that constitute hospice care.

(g)(1) * * *

(4) This subsection does not apply to medical services that constitute hospice care.

(h) Notwithstanding any other provision of this section, a veteran who is catastrophically disabled shall not be required to make any payment otherwise required under subsection (f) or (g) for the receipt of hospital care or nursing home care under this section.

[(h)] *(i)* Nothing in this section requires the Secretary to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty under law to provide care in an institution of such government.

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SEC. 1710A. REQUIRED NURSING HOME CARE.

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(c) The Secretary shall ensure that nursing home care provided under subsection (a) is provided in an age-appropriate manner.

[(c)] *(d)* The provisions of subsection (a) shall terminate on December 31, 2008.

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SEC. 1710C. TRAUMATIC BRAIN INJURY: PLANS FOR REHABILITATION AND REINTEGRATION INTO THE COMMUNITY.

(a) PLAN REQUIRED.—The Secretary shall, for each veteran or member of the Armed Forces who receives inpatient or outpatient rehabilitation care from the Department for a traumatic brain injury—

(1) develop an individualized plan for the rehabilitation and reintegration of such individual into the community; and

(2) provide such plan in writing to such individual before such individual is discharged from inpatient care, following transition from active duty to the Department for outpatient care, or as soon as practicable following diagnosis.

(b) CONTENTS OF PLAN.—Each plan developed under subsection (a) shall include, for the individual covered by such plan, the following:

(1) Rehabilitation objectives for improving the physical, cognitive, and vocational functioning of such individual with the goal of maximizing the independence and reintegration of such individual into the community.

(2) Access, as warranted, to all appropriate rehabilitative components of the traumatic brain injury continuum of care.

(3) A description of specific interventions, rehabilitative treatments, and other services to achieve the objectives described in paragraph (1), which description shall set forth the type, frequency, duration, and location of such interventions, treatments, and services.

(4) The name of the case manager designated in accordance with subsection (d) to be responsible for the implementation of such plan.

(5) Dates on which the effectiveness of the plan will be reviewed in accordance with subsection (f).

(c) COMPREHENSIVE ASSESSMENT.—

(1) IN GENERAL.—Each plan developed under subsection (a) shall be based upon a comprehensive assessment, developed in accordance with paragraph (2), of—

(A) the physical, cognitive, vocational, and neuropsychological and social impairments of such individual; and

(B) the family education and family support needs of such individual after discharge from inpatient care.

(2) FORMATION.—The comprehensive assessment required under paragraph (1) with respect to an individual is a comprehensive assessment of the matters set forth in that paragraph by a team, composed by the Secretary for purposes of the assessment from among, but not limited to, individuals with expertise in traumatic brain injury, including the following:

(A) A neurologist or neuropsychiatrist.
(B) A rehabilitation physician.
(C) A social worker.
(D) A neuropsychologist.
(E) A physical therapist.
(F) A vocational rehabilitation specialist.
(G) An occupational therapist.
(H) A speech language pathologist.
(I) A rehabilitation nurse.
(J) An educational therapist.
(K) An audiologist.
(L) A blind rehabilitation specialist.
(M) A recreational therapist.
(N) A low vision optometrist.
(O) An orthotist or prosthetist.
(P) An assistive technologist or rehabilitation engineer.
(Q) An ophthalmologist.
(R) An otolaryngology physician.
(S) A dietician.

(d) CASE MANAGER.—(1) The Secretary shall designate a case manager for each individual described in subsection (a) to be responsible for the implementation of the plan, and coordination of such care, required by such subsection for such individual.

(2) The Secretary shall ensure that such case manager has specific expertise in the care required by the individual to whom such case manager is designated, regardless of whether such case man-

ager obtains such expertise through experience, education, or training.

(e) PARTICIPATION AND COLLABORATION IN DEVELOPMENT OF PLANS.—(1) The Secretary shall involve each individual described in subsection (a), and the family or legal guardian of such individual, in the development of the plan for such individual under that subsection to the maximum extent practicable.

(2) The Secretary shall collaborate in the development of a plan for an individual under subsection (a) with a State protection and advocacy system if—

(A) the individual covered by such plan requests such collaboration; or

(B) in the case such individual is incapacitated, the family or guardian of such individual requests such collaboration.

(3) In the case of a plan required by subsection (a) for a member of the Armed Forces who is on active duty, the Secretary shall collaborate with the Secretary of Defense in the development of such plan.

(4) In developing vocational rehabilitation objectives required under subsection (b)(1) and in conducting the assessment required under subsection (c), the Secretary shall act through the Under Secretary for Health in coordination with the Vocational Rehabilitation and Employment Service of the Department of Veterans Affairs.

(f) EVALUATION.—

(1) PERIODIC REVIEW BY SECRETARY.—The Secretary shall periodically review the effectiveness of each plan developed under subsection (a). The Secretary shall refine each such plan as the Secretary considers appropriate in light of such review.

(2) REQUEST FOR REVIEW BY VETERANS.—In addition to the periodic review required by paragraph (1), the Secretary shall conduct a review of the plan of a veteran under paragraph (1) at the request of such veteran, or in the case that such veteran is incapacitated, at the request of the guardian or the designee of such veteran.

(g) STATE DESIGNATED PROTECTION AND ADVOCACY SYSTEM DEFINED.—In this section, the term 'State protection and advocacy system' means a system established in a State under subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15041 et seq.) to protect and advocate for the rights of persons with development disabilities.

SEC. 1710D. TRAUMATIC BRAIN INJURY: USE OF NON-DEPARTMENT FACILITIES FOR REHABILITATION.

(a) IN GENERAL.—Subject to section 1710(a)(4) of this title and subsection (b) of this section, the Secretary shall provide rehabilitative treatment or services to implement a plan developed under section 1710C of this title at a non-Department facility with which the Secretary has entered into an agreement for such purpose, to an individual—

(1) who is described in section 1710C(a) of this title; and

(2)(A) to whom the Secretary is unable to provide such treatment or services at the frequency or for the duration prescribed in such plan; or

(B) for whom the Secretary determines that it is optimal with respect to the recovery and rehabilitation of such individual.

(b) STANDARDS.—The Secretary may not provide treatment or services as described in subsection (a) at a non-Department facility under such subsection unless such facility maintains standards for the provision of such treatment or services established by an independent, peer-reviewed organization that accredits specialized rehabilitation programs for adults with traumatic brain injury.

(c) AUTHORITIES OF STATE PROTECTION AND ADVOCACY SYSTEMS.—With respect to the provision of rehabilitative treatment or services described in subsection (a) in a non-Department facility, a State designated protection and advocacy system established under subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15041 et seq.) shall have the authorities described under such subtitle.

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SEC. 1712. DENTAL CARE; DRUGS AND MEDICINES FOR CERTAIN DISABLED VETERANS; VACCINES.

(a)(1) * * *

(B) * * *

(iv) the veteran's certificate of discharge or release from active duty does not bear a certification that the veteran was provided, within the **[**90-day**]** *180-day* period immediately before the date of such discharge or release, a complete dental examination (including dental X-rays) and all appropriate dental services and treatment indicated by the examination to be needed;

* * * * * * *

Subchapter III—Miscellaneous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

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SEC. 1730A. HOSPITAL QUALITY REPORT CARD INITIATIVE.

(a) IN GENERAL.—Not later than 18 months after the date of the enactment of this section, the Secretary shall establish and implement a Hospital Quality Report Card Initiative (in this section referred to as the 'Initiative') to report on health care quality in VA hospitals.

(b) AVAILABILITY OF INFORMATION ON QUALITY AND PERFORMANCE OF VA HOSPITALS.—(1)(A) Under the initiative, the Secretary shall make available to the public the most current information on the quality and performance of each VA hospital on the Internet web site or in the promotional literature of each such VA hospital. Such information shall include quality measures that allow for an assessment of the following, with respect to health care provided by VA hospitals:

(i) Effectiveness.

(ii) Safety.

(iii) Timeliness.

(iv) Efficiency.

(v) Patient satisfaction.

(B) In reporting information pursuant to subparagraph (A), the Secretary may display or provide links to reports or analyses on VA

hospital quality and performance from all available objective sources, which may include the following:

(i) The Joint Commission on Accreditation of Healthcare Organizations.

(ii) The Office of the Inspector General.

(iii) The Office of the Medical Inspector.

(iv) Offices of the Department involved in the collection and dissemination of data on the performance of individual hospitals.

(v) National and local media entities.

(vi) Professional journals.

(vii) Such other sources as the Secretary considers appropriate.

(C) In reporting information as provided for under subparagraph (A), the Secretary may risk adjust quality measures to account for differences relating to—

(i) the characteristics of the reporting VA hospital, such as licensed bed size, geography, and teaching hospital status; and

(ii) patient characteristics, such as health status, severity of illness, and socioeconomic status.

(D) Under the Initiative, the Secretary may verify information reported under this paragraph to ensure accuracy and validity.

(E) The Secretary shall disclose the nature and scope of information reported under this paragraph to all VA hospitals that are the subject of any such information.

(F)(i) The Secretary shall inform the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives of the nature and scope of information to be reported under this paragraph.

(ii) The Secretary shall ensure that information on health care quality is provided in a manner that is conducive for comparisons with other local hospitals or regional hospitals, as appropriate.

(iii) The Secretary shall establish procedures for making information under this paragraph available to the public in accordance with the requirements of subparagraph (A).

(G) The analytic methodologies and limitations on information sources utilized by the Secretary to develop and disseminate information under this paragraph may be identified and acknowledged in a notice or disclaimer, and may include the appropriate and inappropriate uses of such information.

(H) Not less frequently than annually, the Secretary may compare quality measures data submitted by each VA hospital to the Secretary with quality measures data submitted to the Secretary in the prior year or years by each such VA hospital in order to identify actions that could lead to false or artificial improvements in the quality measurements of such VA hospitals.

(2)(A) The Secretary shall develop and implement effective safeguards to protect against the unauthorized use or disclosure of VA hospital data that is reported under this section.

(B) The Secretary shall develop and implement effective safeguards to protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective VA hospital data.

(C) The Secretary shall ensure that identifiable patient data shall not be released to the public.

(c) DEFINITION OF VA HOSPITAL.—In this section, the term 'VA hospital' means a Department of Veterans Affairs Medical Center administered by the Secretary.

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PART II—GENERAL BENEFITS

CHAPTER 20—BENEFITS FOR HOMELESS VETERANS

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Sec.

[2023. Demonstration program of referral and counseling for veterans transitioning from certain institutions who are at risk for homelessness.]

2023. Referral and counseling services: veterans at risk of homelessness who are transitioning from certain institutions.

* * *

2044. Financial assistance for supportive services for very low-income veteran families in permanent housing.

* * * * * * *

Subchapter II—Comprehensive Service Programs

SEC. 2011. GRANTS.

* * * * * * *

(i) AVAILABILITY OF GRANT FUNDS FOR SERVICE CENTER PERSONNEL.—A grant under this section for a service center for homeless veterans may be used to provide funding for staff as necessary in order for the center to meet the service availability requirements of subsection(g)(1).

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SEC. 2012. PER DIEM PAYMENTS.

(a)(1) * * *

(2)(A) [The rate] *Except as provided in subparagraph (B), the rate* for such per diem payments shall be the daily cost of care estimated by the grant recipient or eligible entity [adjusted by the Secretary under subparagraph (B)].

(B) In no case may the rate determined under this paragraph exceed the rate authorized for State homes for domiciliary care under subsection (a)(1)(A) of section 1741 of this title, as the Secretary may increase from time to time under subsection (c) of that section.

[(B) The Secretary shall adjust the rate estimated by the grantrecipient or eligible entity under subparagraph (A) to exclude other sources of income described in subparagraph (D) that the grant recipient or eligible entity certifies to be correct.]

(C) Each grant recipient or eligible entity shall provide to the Secretary such information with respect to other sources of income as the Secretary may require [to make the adjustment under subparagraph (B)].

[(D) The other sources of income referred to in subparagraphs (B) and (C) are payments to the grant recipient or eligible entity for furnishing services to homeless veterans under programs other

than under this subchapter, including payments and grants from other departments and agencies of the United States, from departments or agencies of State or local government, and from private entities or organizations.]

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Subchapter III—Training and Outreach

SEC. 2022. COORDINATION OF OUTREACH SERVICES FOR VETERANS AT RISK OF HOMELESSNESS.

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(f)(1) * * *

(2) * * *

(C) A description of the implementation and operation of the [demonstration] program under section 2023 of this title.

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SEC. 2023. [DEMONSTRATION PROGRAM OF REFERRAL AND COUNSELING FOR VETERANS TRANSITIONING FROM CERTAIN INSTITUTIONS WHO ARE AT RISK FOR HOMELESSNESS.] *REFERRAL AND COUNSELING SERVICES: VETERANS AT RISK OF HOMELESSNESS WHO ARE TRANSITIONING FROM CERTAIN INSTITUTIONS.*

(a) PROGRAM AUTHORITY.—The Secretary and the Secretary of Labor (hereinafter in this section referred to as the "Secretaries") shall carry out [a demonstration program for the purpose of determining the costs and benefits of providing] *a program of* referral and counseling services to eligible veterans with respect to benefits and services available to such veterans under this title and under State law.

(b) LOCATION OF [DEMONSTRATION] PROGRAM.—The [demonstration] program shall be carried out [in at least six locations] *in at least 12 locations*. One location shall be a penal institution under the jurisdiction of the Bureau of Prisons.

(c) SCOPE OF PROGRAM.—(1) To the extent practicable, the [demonstration] program shall provide both referral and counseling services, and in the case of counseling services, shall include counseling with respect to job training and placement (including job readiness), housing, health care, and other benefits to assist the eligible veteran in the transition from institutional living.

* * * * * * *

(d) DURATION.—The authority of the Secretaries to provide referral and counseling services under the demonstration program [shall cease on the date that is four years after the date of the commencement of the program] *shall cease on September 30, 2011*.

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Subchapter V—Housing Assistance

SEC. 2043. DOMICILIARY CARE PROGRAMS.

* * * * * * *

[(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary $5,000,000 for each of fiscal

years 2003 and 2004 to establish the programs referred to in subsection (a).]

(b) ENHANCEMENT OF CAPACITY OF DOMICILIARY CARE PROGRAMS FOR FEMALE VETERANS.—The Secretary shall take appropriate actions to ensure that the domiciliary care programs of the Department are adequate, with respect to capacity and with respect to safety, to meet the needs of veterans who are women.

SEC. 2044. FINANCIAL ASSISTANCE FOR SUPPORTIVE SERVICES FOR VERY LOW-INCOME VETERAN FAMILIES IN PERMANENT HOUSING.

(a) DISTRIBUTION OF FINANCIAL ASSISTANCE.—(1) The Secretary shall provide financial assistance to eligible entities approved under this section to provide and coordinate the provision of supportive services described in subsection (b) for very low-income veteran families occupying permanent housing.

(2) Financial assistance under this section shall consist of grants for each such family for which an approved eligible entity is providing or coordinating the provision of supportive services.

(3)(A) The Secretary shall provide such grants to each eligible entity that is providing or coordinating the provision of supportive services.

(B) The Secretary is authorized to establish intervals of payment for the administration of such grants and establish a maximum amount to be awarded, in accordance with the services being provided and their duration.

(4) In providing financial assistance under paragraph (1), the Secretary shall give preference to entities providing or coordinating the provision of supportive services for very low-income veteran families who are transitioning from homelessness to permanent housing.

(5) The Secretary shall ensure that, to the extent practicable, financial assistance under this subsection is equitably distributed across geographic regions, including rural communities and tribal lands.

(6) Each entity receiving financial assistance under this section to provide supportive services to a very low-income veteran family shall notify that family that such services are being paid for, in whole or in part, by the Department.

(7) The Secretary may require entities receiving financial assistance under this section to submit a report to the Secretary that describes the projects carried out with such financial assistance.

(b) SUPPORTIVE SERVICES.—The supportive services referred to in subsection (a) are the following:

(1) Services provided by an eligible entity or a subcontractor of an eligible entity that address the needs of very low-income veteran families occupying permanent housing, including—

(A) outreach services;

(B) case management services;

(C) assistance in obtaining any benefits from the Department which the veteran may be eligible to receive, including, but not limited to, vocational and rehabilitation counseling, employment and training service, educational assistance, and health care services;

(D) assistance in obtaining and coordinating the provision of other public benefits provided in federal, State, or local agencies, or any organization defined in subsection (f), including—

(i) health care services (including obtaining health insurance);

(ii) daily living services;

(iii) personal financial planning;

(iv) transportation services;

(v) income support services;

(vi) fiduciary and representative payee services;

(vii) legal services to assist the veteran family with issues that interfere with the family's ability to obtain or retain housing or supportive services;

(viii) child care;

(ix) housing counseling; and

(x) other services necessary for maintaining independent living.

(2) Services described in paragraph (1) that are delivered to very low-income veteran families who are homeless and who are scheduled to become residents of permanent housing within 90 days pending the location or development of housing suitable for permanent housing.

(3) Services described in paragraph (1) for very low-income veteran families who have voluntarily chosen to seek other housing after a period of tenancy in permanent housing, that are provided, for a period of 90 days after such families exit permanent housing or until such families commence receipt of other housing services adequate to meet their current needs, but only to the extent that services under this paragraph are designed to support such families in their choice to transition into housing that is responsive to their individual needs and preferences.

(c) APPLICATION FOR FINANCIAL ASSISTANCE.—(1) An eligible entity seeking financial assistance under subsection (a) shall submit to the Secretary an application therefor in such form, in such manner, and containing such commitments and information as the Secretary determines to be necessary to carry out this section.

(2) Each application submitted by an eligible entity under paragraph (1) shall contain—

(A) a description of the supportive services proposed to be provided by the eligible entity and the identified needs for those services;

(B) a description of the types of very low-income veteran families proposed to be provided such services;

(C) an estimate of the number of very low-income veteran families proposed to be provided such services;

(D) evidence of the experience of the eligible entity in providing supportive services to very low-income veteran families; and

(E) a description of the managerial capacity of the eligible entity—

(i) to coordinate the provision of supportive services with the provision of permanent housing by the eligible entity or by other organizations;

(ii) to assess continuously the needs of very low-income veteran families for supportive services;

(iii) to coordinate the provision of supportive services with the services of the Department;

(iv) to tailor supportive services to the needs of very low-income veteran families; and

(v) to seek continuously new sources of assistance to ensure the long-term provision of supportive services to very low-income veteran families.

(3) The Secretary shall establish criteria for the selection of eligible entities to be provided financial assistance under this section.

(d) TECHNICAL ASSISTANCE.—(1) The Secretary shall provide training and technical assistance to participating eligible entities regarding the planning, development, and provision of supportive services to very low-income veteran families occupying permanent housing, through the Technical Assistance grants program in section 2064 of this title.

(2) The Secretary may provide the training described in paragraph (1) directly or through grants or contracts with appropriate public or nonprofit private entities.

(e) FUNDING.—(1) From amounts appropriated to the Department for Medical Services, there shall be available to carry out subsection (a), (b), and (c) amounts as follows:

(A) $15,000,000 for fiscal year 2008.

(B) $20,000,000 for fiscal year 2009.

(C) $25,000,000 for fiscal year 2010.

(2) Not more than $750,000 may be available under paragraph (1) in any fiscal year to provide technical assistance under subsection (d).

(3) There is authorized to be appropriated $1,000,000 for each of the fiscal year 2008 through 2010 to carry out the provisions of subsection (d).

(f) DEFINITIONS.—In this section:

(1) The term 'consumer cooperative' has the meaning given such term in section 202 of the Housing Act of 1959 (12 U.S.C. 1701q).

(2) The term 'eligible entity' means—

(A) a private nonprofit organization; or

(B) a consumer cooperative.

(3) The term 'homeless' has the meaning given that term in section 103 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11302).

(4) The term 'permanent housing' means community-based housing without a designated length of stay.

(5) The term 'private nonprofit organization' means any of the following:

(A) Any incorporated private institution or foundation—

(i) no part of the net earnings of which inures to the benefit of any member, founder, contributor, or individual;

(ii) which has a governing board that is responsible for the operation of the supportive services provided under this section; and

(iii) which is approved by the Secretary as to financial responsibility;

(B) A for-profit limited partnership, the sole general partner of which is an organization meeting the requirements of clauses (i), (ii), and (iii) of subparagraph (A).

(C) A corporation wholly owned and controlled by an organization meeting the requirements of clauses (i), (ii), and (iii) of subparagraph (A).

(D) A tribally designated housing entity (as defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103)).

(6)(A) Subject to subparagraphs (B) and (C), the term 'very low-income veteran family' means a veteran family whose income does not exceed 50 percent of the median income for an area specified by the Secretary for purposes of this section, as determined by the Secretary in accordance with this paragraph.

(B) The Secretary shall make appropriate adjustments to the income requirement under subparagraph (A) based on family size.

(C) The Secretary may establish an income ceiling higher or lower than 50 percent of the median income for an area if the Secretary determines that such variations are necessary because the area has unusually high or low construction costs, fair market rents (as determined under section 8 of the United States Housing Act of 1937 (42 U.S.C. 1437f)), or family incomes.

(7) The term 'veteran family' includes a veteran who is a single person and a family in which the head of household or the spouse of the head of household is a veteran.

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PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

CHAPTER 73—VETERANS HEALTH ADMINISTRATION—ORGANIZATION AND FUNCTIONS

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Sec.

[7324. Annual report on use of authorities to enhance retention of experienced nurses.]

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7330A. Severe traumatic brain injury research, education, and clinical care program.

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Subchapter II—General Authority and Administration

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[SEC. 7324. ANNUAL REPORT ON USE OF AUTHORITIES TO ENHANCE RETENTION OF EXPERIENCED NURSES.]

[(a) ANNUAL REPORT. Not later than January 31 each year, the Secretary, acting through the Under Secretary for Health, shall submit to Congress a report on the use during the preceding year of authorities for purposes of retaining experienced nurses in the Veterans Health Administration, as follows:

[(1) The authorities under chapter 76 of this title.

[(2) The authority under VA Directive 5102.1, relating to the Department of Veterans Affairs nurse qualification standard, dated November 10, 1999, or any successor directive.

[(3) Any other authorities available to the Secretary for those purposes.]

[(b) Report elements. Each report under subsection (a) shall specify for the period covered by such report, for each Department medical facility and for each geographic service area of the Department, the following:

[(1) The number of waivers requested under the authority referred to in subsection (a)(2), and the number of waivers granted under that authority, to promote to the Nurse II grade or Nurse III grade under the Nurse Schedule under section 7404(b)(1) of this title any nurse who has not completed a baccalaureate degree in nursing in a recognized school of nursing, set forth by age, race, and years of experience of the individuals subject to such waiver requests and waivers, as the case may be.

[(2) The programs carried out to facilitate the use of nursing education programs by experienced nurses, including programs for flexible scheduling, scholarships, salary replacement pay, and on-site classes.]

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SEC. 7330A. SEVERE TRAUMATIC BRAIN INJURY RESEARCH, EDUCATION, AND CLINICAL CARE PROGRAM.

(a) PROGRAM REQUIRED.—The Secretary shall establish a program on research, education, and clinical care to provide intensive neuro-rehabilitation to veterans with a severe traumatic brain injury, including veterans in a minimally conscious state who would otherwise receive only long-term residential care.

(b) COLLABORATION REQUIRED.—The Secretary shall establish the program required by subsection (a) in collaboration with the Defense and Veterans Brain Injury Center and academic institutions selected by the Secretary from among institutions having an expertise in research in neuro-rehabilitation.

(c) EDUCATION REQUIRED.—As part of the program required by subsection (a), the Secretary shall, in collaboration with the Defense and Veterans Brain Injury Center, conduct educational programs on recognizing and diagnosing mild and moderate cases of traumatic brain injury.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary for each of fiscal years 2008 through 2012, $10,000,000 to carry out the program required by subsection (a).

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CHAPTER 74—VETERANS HEALTH ADMINISTRATION—PERSONNEL

Subchapter IV—Pay for Nurses and Other Health-Care Personnel

SEC. 7451. NURSES AND OTHER HEALTH-CARE PERSONNEL: COMPETITIVE PAY.

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(c)(1) For each grade in a covered position, there shall be a range of basic pay. The maximum rate of basic pay for a grade shall be 133 percent of the minimum rate of basic pay for the grade, except that, if the Secretary determines that a higher maximum rate is necessary with respect to any such grade in order to recruit and retain a sufficient number of high-quality health-care personnel, the Secretary may raise the maximum rate of basic pay for that grade to a rate not in excess of 175 percent of the minimum rate of basic pay for the grade. Whenever the Secretary exercises the authority under the preceding sentence to establish the maximum rate of basic pay at a rate in excess of 133 percent of the minimum rate for that grade, the Secretary shall**[**, in the next annual report required by subsection (g), (1)**]** provide justification for doing so to the Committees on Veterans' Affairs of the Senate and House of Representatives.

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(e)(1) * * *

[(5) Not later than September 30 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on staffing for covered positions at Department health care facilities. Each such report shall include the following:

[(A) A summary and analysis of the information contained in the most recent reports submitted by facility directors under paragraph (4).

[(B) The information for each such facility specified in paragraph (4).**]**

[(f) Not later than March 1 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report regarding any pay adjustments under the authority of subsection (d) effective during the 12 months preceding the submission of the report. Each such report shall set forth, by health-care facility, the percentage of such increases and, in any case in which no increase was made, the basis for not providing an increase.**]**

[(g)**]** *(f)* For the purposes of this section, the term "health-care facility" means a medical center, an independent outpatient clinic, or an independent domiciliary facility.

SEC. 7452. NURSES AND OTHER HEALTH-CARE PERSONNEL: ADMINISTRATION OF PAY.

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(b)**[**(1) Under regulations**]** *Under regulations* which the Secretary prescribes for the administration of this section, the director of a Department healthcare facility (A) shall pay a cash bonus (in

an amount to be determined by the director not to exceed $2,000) to an employee in a covered position at that facility who becomes certified in a specialty recognized by the Department, and (B) may provide such a bonus to an employee in such a position who has demonstrated both exemplary job performance and exemplary job achievement. The authority of the Secretary under this subsection is in addition to any other authority of the Secretary to provide job performance incentives.

[(2) The Secretary shall include in the annual report under section 7451(g) (1) of this title a discussion of the use during the period covered by the report of the payment of bonuses under this subsection and other job performance incentives available to the Secretary.]

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(e) An employee in a covered position employed under section 7401(1) of this title who (without a break in employment) transfers from one Department health-care facility to another may not be reduced in grade or step within grade (except pursuant to a disciplinary action otherwise authorized by law) if the duties of the position to which the employee transfers are similar to the duties of the position from which the employee transferred. The rate of basic pay of such employee shall be established at the new health-care facility in a manner consistent with the practices at that facility for an employee of that grade and step, except that in the case of an employee whose transfer (other than pursuant to a disciplinary action otherwise authorized by law) to another healthcare facility is at the request of the Secretary, the Secretary may provide that for at least the first year following such transfer the employee shall be paid at a rate of basic pay up to the rate applicable to such employee before the transfer, if the Secretary determines that such rate of pay is necessary to fill the position. [Whenever the Secretary exercises the authority under the preceding sentence relating to the rate of basic pay of a transferred employee, the Secretary shall, in the next annual report required under section 7451(g) (1) of this title, provide justification for doing so.]

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CHAPTER 76—HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

Subchapter II—Scholarship Program

SEC. 7618. EXPIRATION OF PROGRAM.

The Secretary may not furnish scholarships to new participants in the Scholarship Program after [December 31, 1998] *December 31, 2012*.

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY; ENHANCED-USE LEASES OF REAL PROPERTY

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Subchapter I—Acquisition and Operation of Medical Facilities

[SEC. 8107. OPERATIONAL AND CONSTRUCTION PLANS FOR MEDICAL FACILITIES.]

[(a) In order to promote effective planning for the efficient provision of care to eligible veterans, the Secretary, based on the analysis and recommendations of the Under Secretary for Health, shall submit to each committee an annual report regarding long-range health planning of the Department. The report shall be submitted each year not later than the date on which the budget for the next fiscal year is submitted to the Congress under section 1105 of title 31.

[(1) A five-year strategic plan for the provision of care under chapter 17 of this title to eligible veterans through coordinated networks of medical facilities operating within prescribed geographic service-delivery areas, such plan to include provision of services for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) through distinct programs or facilities of the Department dedicated to the specialized needs of those veterans.

[(2) A description of how planning for the networks will be coordinated.

[(3), (4) [Deleted]]

[(c) The Secretary shall submit to each committee not later than January 31 of each year a report showing the location, space, cost, and status of each medical facility (1) the construction, alteration, lease, or other acquisition of which has been approved under section 8104(a) of this title, and (2) which was uncompleted as of the date of the last preceding report made under this subsection.]

[(d) (1) The Secretary shall submit to each committee, not later than January 31 of each year, a report showing the current priorities of the Department for proposed major medical construction projects. Each such report shall identify the 20 projects, from within all the projects in the Department's inventory of proposed projects, that have the highest priority and, for those 20 projects, the relative priority and rank scoring of each such project and the projected cost of such project (including the projected operating costs, including both recurring and nonrecurring costs). The 20 projects shall be compiled, and their relative rankings shall be

shown, by category of project (including the categories of ambulatory care projects, nursing home care projects, and such other categories as the Secretary determines).

[(2) The Secretary shall include in each report, for each project listed, a description of the specific factors that account for the relative ranking of that project in relation to other projects within the same category.

[(3) In a case in which the relative ranking of a proposed project has changed since the last report under this subsection was submitted, the Secretary shall also include in the report a description of the reasons for the change in the ranking, including an explanation of any change in the scoring of the project under the Department's scoring system for proposed major medical construction projects.]

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Subchapter IV—Sharing of Medical Facilities, Equipment, and Information

SEC. 8153. SHARING OF HEALTH-CARE RESOURCES.

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[(g) The Secretary shall submit to the Congress not later than February 1 of each year a report on the activities carried out under this section during the preceding fiscal year. Each report shall include—

[(1) an appraisal of the effectiveness of the activities authorized in this section and the degree of cooperation from other sources, financial and otherwise; and

[(2) recommendations for the improvement or more effective administration of such activities.]

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